Georgia Department of Community Health

Georgia Families

Hospital Provider Issues and Concerns

January 14, 2008

Prepared By:

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Table of Contents

Attachments

The following listing of terms and references are used throughout this report:

- Adjudicate – A determination of the outcome of a healthcare claim. Claims may pay, deny, or in some cases have an alternative adjudication outcome.

- Ambulatory Surgical Center (ASC) – A healthcare service location in which surgical procedures are the primary focus of care.

- Ambulatory Surgical Center (ASC) Group – A listing of codes each of which represent similar types of surgical services.

- Appeal – A formal process whereby a healthcare provider requests that a payor review the outcome of a claim previously submitted to the payor for reimbursement. This term is typically reserved for claims that were originally denied for payment by the payor, however the provider believes a payment should be made.

- Capitation claim - A per Medicaid and/or PeachCare for Kids™ member fixed payment amount made by DCH to a care management organization in return for the administration and provision of healthcare services rendered to the enrolled Medicaid and/or PeachCare for Kids™ member.

- Care Management Organization (CMO) – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid or PeachCare for Kids™ members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member.

- Centers for Medicare and Medicaid Services (CMS) – The federal agency under the Department of Health and Human Services responsible for the oversight and administration of the federal Medicare program, state Medicaid programs, and State Children's Health Insurance Programs.

- Centers for Medicare and Medicaid Services 1500 (CMS-1500 or "1500") Claim Form – Document most often required by payors to be utilized by physicians and other non-institutional providers for submission of a claim request for reimbursement to the healthcare payor.

- Claims Processing System – A computer system or set of systems that determine the reimbursement amount for services billed by the healthcare provider.

- Current Procedural Terminology (CPT) Codes – A listing of five character alphanumeric codes for use in reporting medical services and procedures

performed by healthcare providers. CPT codes generally begin with a numeric character.

- Denied Claim – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the healthcare provider and payor.

- Diagnosis Related Group (DRG) – A group assigned to an inpatient hospital episode of care. Groups are based on similar resource requirements for the treatment of medical conditions. Claims are assigned a group using diagnosis and procedure codes, the age and sex of the patient, the patient status, and birth weight for neonates.

- Emergency Medical Treatment and Active Labor Act (EMTALA) – As it pertains to this report, a portion of the Consolidated Omnibus Budget Reconciliation Act of 1986 (OBRA '86) statute that outlines the patient's rights and guidelines to prevent denial of emergency treatment.

- Georgia Families (GF) – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ where the Department contracts with Care Management Organizations to manage the care of eligible members.

- Global Fee – A payment for a healthcare service that includes both the professional and technical components of the service.

- Fee-For-Service (FFS) – A healthcare delivery system in which a healthcare provider receives a specific reimbursement amount from the payor for each healthcare service provided to a patient.

- Fee-for-service (FFS) claim - A payment made by a payor to a healthcare provider after a service has been provided to a patient covered by the payor. In some cases, the service must be authorized in advance. A FFS claim consists of one or more line items that detail all specific healthcare service(s) provided.

- Healthcare Common Procedure Coding System Level II Codes (HCPCS Codes) – A listing of five character alphanumeric codes for use in reporting medical services, supplies, devices, and drugs utilized by healthcare providers.

- Kick Payment – A one-time payment made to a CMO for a newborn baby. This payment is in addition to the monthly capitation claim payment for the newborn and is intended to help offset the cost of labor and delivery.

- Medicaid Management Information System (MMIS) – Claims processing system used by the Department's fiscal agent claims processing vendor to

process Georgia Medicaid and PeachCare for Kids™ FFS claims and capitation claims.

- Medical Record – A document or series of documents that detail a patient's medical history, including at least the medical diagnoses, services rendered by healthcare providers, informed consent and treatment plan.

- Paid Claim – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the healthcare provider and payor.

- Payor – An entity that reimburses a healthcare provider a portion or the entire healthcare expenses of a patient for whom the entity is financially responsible.

- PeachCare for Kids™ program (PeachCare) – The Georgia DCH's State Children's Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.

- Prior Authorization (Authorization, PA, or Pre-Certification) – An approval given by a healthcare payor to a healthcare provider before a healthcare service is performed that allows the provider to perform a specific healthcare service for a patient who is the financial responsibility of the payor with the understanding that the payor will reimburse the provider for the service since the payor approved the service prior to the service being performed.

- Professional Services Claim (Professional Claim) – A healthcare claim for reimbursement of services provided by a physician or other non-institutional provider.

- Provider Manual – A document created by a healthcare payor that describes the coverages and payment policies for healthcare providers that provide healthcare services to patients covered by the payor.

- Provider Number (or Provider Billing Number) – An alphanumeric code utilized by healthcare payors to identify providers for billing, payment, and reporting purposes.

- Prudent Layperson – A standard used to define what is or is not an emergency medical condition. The standard is determined by asking, "would a reasonable person, excluding the patient, believe that the patient's healthcare condition requires emergency medical care?"

- Reconsideration – A process whereby a healthcare provider requests that a payor review the outcome of a claim previously submitted to the payor for reimbursement. This term is typically reserved for claims that were originally

reimbursed by the payor, however the provider disagrees with the amount paid.

- Remittance Advice (RA) – A document provided by a healthcare payor to a healthcare provider that lists healthcare claims billed by the provider to the payor and explains the payment (or denial) of those claims.

- Resolution – The outcome of an issue, disagreement, problem, or situation in which all parties agree that the issue, disagreement, problem, or situation no longer requires action.

- Revenue Codes – A listing of three digit numeric codes utilized by institutional healthcare providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).

- Technical Component Claim – A healthcare claim for reimbursement of the overhead portion of a healthcare service.

- Triage – The process of reviewing a patient's condition to determine the medical priority and the need for emergency treatment.

- Triage Rate – The reimbursement rate paid to a provider when a patient enters the emergency room but is deemed to not be in need of emergency care.

- Uniform Billing (UB or UB-92 or UB-04) Claim Form – Document most often required by payors to be utilized by hospitals and other institutional providers for submission of a claim request for reimbursement to the healthcare payor. The UB-92 version of the claim form was replaced by the UB-04 version in 2007. CMS refers to the UB-92/UB-04 claim form as the CMS-1450 claim form.

Background

In July 2005, the Georgia Department of Community Health (DCH or Department) contracted with Amerigroup Community Care ("Amerigroup"), Peach State Health Plan ("PSHP") and WellCare of Georgia (WellCare), (hereinafter referenced as "CMOs") to provide healthcare services under the Georgia Families care management program. This risk-based managed care program is designed to bring together private health plans, healthcare providers, and patients to work proactively to improve the health status of Georgia's Medicaid and PeachCare for Kids™ members. Approximately 600,000 members in the Atlanta and Central regions of the state began receiving healthcare services through Georgia Families on June 1, 2006. Georgia Families was expanded statewide to the remaining four regions, and approximately 400,000 additional members, on September 1, 2006.

The objective of the Georgia Families program is to strengthen the state's healthcare system by allowing members the option of choosing a health plan that best suits their needs; providing health education and prevention programs; and assisting members find doctors and specialists when necessary. When participating in the Georgia Families program, members are assigned a primary care provider, in part, to establish a medical home and to improve continuity and coordination of care.

Under the Georgia Families program, Medicaid and PeachCare For Kids™ members are eligible for many of the same healthcare services they received under the traditional fee-for-service Medicaid and PeachCare For Kids™ programs. They may also be eligible for additional services offered by the care management organizations.

DCH's contract with the CMOs delineates the requirements each CMO must adhere to, including:

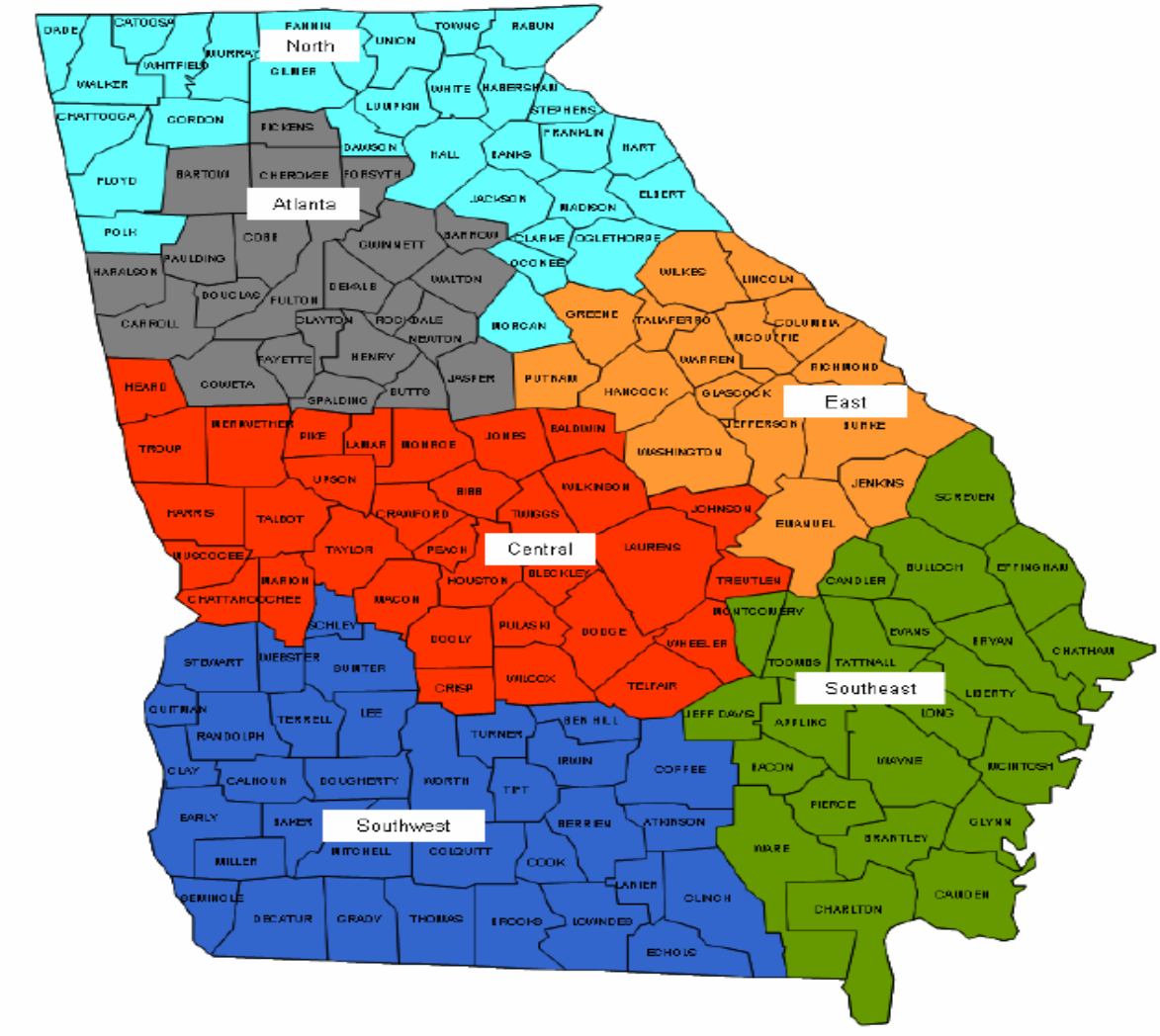
- the covered benefits and services that must be provided to the Medicaid and PeachCare For Kids™ members,
- the provider network and service requirements for the CMOs,
- Medicaid and PeachCare For Kids™ enrollment and disenrollment requirements,
- allowed and disallowed marketing activities,
- general provider contracting provisions,
- quality improvement guidance, and
- reporting requirements, and other areas of responsibility.

In return for the CMOs satisfying the terms of the contract, the Department pays each CMO a monthly capitation payment for each enrolled Medicaid and PeachCare For Kids™ member, as well as kick payments for newborns.

Table 1, below illustrates the participation of the three CMOs by coverage region.

Region	Amerigroup	PSHP	WellCare
Atlanta	√	√	√
Central		√	√
East	√		√
North	√		√
Southeast	√		√
Southwest		√	√

Figure 1, below includes an illustration of the Georgia Families coverage regions.



As noted, each coverage region has at least two CMOs participating, while the Atlanta region includes all three plans.

Within each region, a participating CMO is required to build a network of healthcare providers sufficient to provide access to necessary services for its members. CMOs and providers develop contractual relationships, negotiating payment rates specific to each CMO and provider. Generally, CMOs reimburse hospitals that they contract with at rates that are a negotiated percentage above the Medicaid fee-for-service payment structure. The contracts between a CMO and its other non-hospital network providers are generally structured in a similar manner, with the exception of the negotiated payment rates, which can vary by provider type. Some policy variations may also exist in the various contracts between CMOs and providers. For example, contracts may differ among plans and providers on the number of days a provider has to file a claim for reimbursement after a healthcare service is provided. Contracts between the CMO and provider are generally effective for one year with subsequent automatic renewals. Contracts typically may be terminated by either party upon receipt of a written notice if terminated for reasons other than a breach of contract.

Project Purpose

Following the implementation by DCH of the Georgia Families program, hospitals and other providers began reporting negative experiences with the Georgia Families care management program. In particular, providers reported concerns with claims adjudication by the CMOs. These concerns were reported to the CMOs, the Department of Community Health, members of the Georgia Generally Assembly, the Office of the Governor, and to the hospital and other provider industry associations.

In part due to these provider concerns, the Department of Community Health engaged Myers and Stauffer LC to study and report on specific aspects of the GF program, including certain issues presented by providers, selected claims paid or denied by CMOs, and selected GF policies and procedures. The initial phase of the engagement includes analysis of hospital related issues, claims payment and denial issues, and a review of certain GF and CMO policies and procedures. Subsequent phases of the engagement will include similar reviews related to other provider categories.

Scope of This Report

When State Medicaid programs substantially alter their care delivery model, as was the case with the Georgia Department of Community Health, it is not unusual to experience certain challenges and issues during the transitional phases. These issues could include some or all of the following:

- High volume of claim denials
- Claims mispayments
- Duplicate payments
- Payment delays

- Communication issues
- Provider setup delays
- Contracting issues
- Other transitional issues

Transitional issues could also include philosophical differences among stakeholders regarding appropriate care delivery models (e.g., managed care versus fee-for-service). During the periods following implementation of the Georgia Families program, such issues are typically resolved through common channels such as provider information releases, training and education, and attention to customer service.

Following implementation of Georgia Families it was observed that established lines of communication between providers and Medicaid payers (including working relationships) and policies and procedures were bifurcated among three distinct health plans, each applying somewhat different payment, coverage and other adjudication policies. To participate in the Medicaid program, many providers are now required to follow different billing and payment policies and procedures of four different entities (i.e., three CMOs and the Medicaid fiscal agent contractor). As a result, the DCH reported to us that they had received a substantial volume of correspondence from the hospital industry raising specific issues, problems, or concerns that hospitals were experiencing with the care management organization model. Given the volume of reported issues and the sometimes conflicting information received, as an initial focus of this engagement, the Department requested that Myers and Stauffer analyze and attempt to confirm the reasonableness of the issues and concerns reported by the hospital representatives. The scope of this report is limited to analyzing and summarizing a sample of the concerns reported to Myers and Stauffer LC by Georgia hospital representatives. This report is anticipated to be the first of a number of reports regarding the Care Management Organization delivery model. Subsequent reports will include recommendations, best practices or other observations, as applicable, resulting from these analyses and activities.

Methodology

On September 18, 2007, representatives from DCH and Myers and Stauffer LC met with representatives from each of the three CMOs to discuss this engagement. Each CMO was presented a list of requested documentation and data to supply to Myers and Stauffer LC for analysis.

On September 25, 2007, Myers and Stauffer LC held meetings with hospital industry representatives, including: Hometown Health, VHA Managed Care Council, Georgia Hospital Association, and Children's Healthcare of Atlanta. During these meetings, hospital providers were invited to discuss and submit documentation to illustrate the concerns or problems they were experiencing with claims adjudication or other matters. In order for us to consider any concern or problem for further evaluation, we required that hospitals submit data and other documentary evidence to support their position.

We also required both the hospitals and the CMOs to sign letters attesting to the accuracy and completeness of the information and documentation submitted. These meetings were available to any hospital that desired to participate. Numerous hospitals described issues and problems they were experiencing, and in many cases they also described how these issues impacted their respective facilities.

On September 26, 2007, Myers and Stauffer conducted individual meetings with representatives from Flint River Community Hospital, Tanner Behavioral Health and Children's Healthcare of Atlanta (CHOA) in order to receive greater detail regarding the issues presented by these facilities. These providers were again required to submit issues and supporting documentation directly to Myers and Stauffer LC after the conclusion of the meetings.

Over the following weeks, we received documentation from 33 hospitals to support concerns and problems with CMO claims adjudication and related issues that they previously reported to us. In addition, the Department provided for our review and consideration copies of correspondence they received from the hospital associations and individual facilities. Meetings were also held with the DCH Division of Managed Care & Quality to ascertain the volume and type of issues reported by hospitals. Myers and Stauffer also reviewed the August 28 – August 29, 2007 testimony of hospitals provided to the Joint Appropriations Subcommittee on Health of the Georgia General Assembly.

The issues and documentation submitted to Myers and Stauffer were cataloged, inventoried and compiled into twenty-six (26) issue groups. These groups were analyzed to understand the breadth and scope of hospital issues, to identify priorities, to identify issues that were outside the scope of this engagement, and to determine the distribution and characteristics of the hospital representatives reporting the issue or concern.

Inventory of Issues

Myers and Stauffer LC prepared an inventory of issues and concerns using the information submitted by hospital providers, hospital industry associations, the Department, and the August 28 – August 29, 2007 testimony of hospitals provided to the Joint Appropriations Subcommittee on Health of the Georgia General Assembly. The complete inventory of issues compiled by Myers and Stauffer is included as Attachment A. It is important to note that this inventory does not necessarily present all issues that hospital providers may have experienced, but rather this inventory only presents those issues that the providers voluntarily submitted to Myers and Stauffer LC. It is also important to note that the issues and concerns included in Attachment A were "as reported" by hospitals, and may not necessarily have been confirmed. Lastly, the information contained in Attachment A was last updated on November 13, 2007. Some of the issues and concerns included in Attachment A may have since been resolved.

Table 2 below presents a summary of the hospital issues and concerns reported to Myers and Stauffer, by category. The summary includes the number of times a particular issue was reported ("occurrence count"), the number of hospitals providing comments related to the issue, and if indicated, the CMO (or CMOs) to which each issue applied. Some of the issues and concerns raised by hospital representatives are outside the scope of this engagement, and these matters will be addressed separately by DCH. These issues and concerns are described in Attachment B.

Table 2: Summary of Hospital Issues and Concerns Reported to Myers and Stauffer (September – November 2007)				**Care Management Organization**		
Category	**Summary Description of Issues and Concerns**	**Occurrence Count**	**Hospitals Commenting**	**Amerigroup**	**WellCare**	**Peach State**
12	***Emergency room claims paid at triage rate instead of contracted emergency treatment rate*** –Hospitals indicated that: claims were not paid in accordance with terms of their contracts with CMOs; the criteria to determine the appropriate level of reimbursement were not available; and the need to devote significant resources to reconsider and appeal claims paid at the (lower) triage rates.	30	24	2	20	7
3.1	***CMO not paying according to contractual agreements -*** Hospitals reported that, in some circumstances and to varying degrees, CMOs are not reimbursing the provider according to the terms of the contract. For example, one CMO was reportedly not paying the facility portion of claims for a hospital-based clinic, which is contrary to contractual terms that state these are reimbursable costs.	25	13	1	5	12
11	***Timeliness edit issues, including using admission date to start timeliness determination*** –Hospitals reported issues with the CMO timeliness edits. In particular, the CMOs use the hospital admission date to determine the length of time a hospital has to submit their claim. Furthermore, hospitals reported that reprocessed claims, or claims resubmitted to correct issues, are often denied due to the timeliness edit.	24	12	8	8	10
10	***Contract loading and credentialing, accuracy and length of time*** –Hospitals reported issues with contract rate loading and credentialing, specifically related to the accuracy of the rates, the length of time necessary to complete the load, and issues involving specific groups not being included.	18	11	2	7	7
4	***Utilization Management and Medical Necessity*** –Hospitals reported concerns with the utilization management policies and procedures of the CMOs. Specifically, hospitals reported issues with inconsistent application, application inconsistent with contractual agreements or DCH policy, or the use of these policies to create administrative barriers to receiving claim payments.	17	4	4	7	6

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Category	**Summary Description of Issues and Concerns**	**Occurrence Count**	**Hospitals Commenting**	**Amerigroup**	**WellCare**	**Peach State**
3.9	***Claims processing issues resulting in delayed or denied payment*** –Hospitals reported issues with delayed or denied outlier payments, or DRG grouping issues.	12	8	2	4	5
3.91	***Claim payment amount calculations*** –Hospitals reported issues with claim payment amounts, procedure code or fee schedule payments, or incorrect application of percentage rate calculations.	11	6	4	3	4
3.2	***CMO coding requirements are contrary to accepted standards*** – Myers and Stauffer received comments from provider entities indicating that the three CMOs are, in various circumstances and to varying degrees, not following industry coding standards. For example, one CMO and provider disagree on the appropriate coding for Neonatal Hypermagnesemia. The CMO indicates that only one code should be used on a claim, however the provider consulted with the American Heart Association on the appropriateness of using two codes.	8	7	4	2	3
8	***Claim appeals*** –Hospitals reported concerns with the volume of appeals, the appeals process, and the resources required to file an appeal. Hospitals reported that a high percentage of appeals result in a change of the original decision.	8	4	0	2	2
17	***Provider set-up issues and incorrect set ups*** –Hospitals reported problems with claims billing and payment issues from physician groups, ambulance services, and anesthesia groups.	5	3	2	3	1
16	***Application of the 72 Hour Rule*** –Hospitals reported that CMOs are applying the 72 hour rule inconsistent with Department's policies, or applying the rule to incorrect practice settings.	4	3	0	1	1

Table 2: Summary of Hospital Issues and Concerns Reported to Myers and Stauffer (September – November 2007)				**Care Management Organization**		
Category	**Summary Description of Issues and Concerns**	**Occurrence Count**	**Hospitals Commenting**	**Amerigroup**	**WellCare**	**Peach State**
3.3	***Denial of payment with indication that denied service is part of global payment*** – Myers and Stauffer received comments from provider entities indicating that one of the CMOs is denying payment for services due to the inclusion of the service in a global payment. For example, one provider indicated that payment was denied for anesthesia claims, with an explanation that the service is reimbursed under the surgeon's reimbursement.	3	3	0	0	2
3.6	***Covered, authorized services not paid*** – One hospital reported that services included in the contract have been denied.	2	1	0	1	2
3.7	***Claim denials for hospital-based and out-of-network providers*** – One hospital reported that a hospital claim was denied because the admitting physician was not in the CMOs network. The hospital is in the CMO network.	2	1	1	0	1
5	***The number of services that are subject to pre-certification / pre-authorization.***	38	16	12	16	14
7	***Eligibility issues such as including conflicting information and delays and information load process.***	15	7	1	4	1
15	***Issues related to medical necessity related recoupments and appropriate accounting of the recoupments.***	11	9	0	6	4
1	***Local administration's process for addressing provider issues***	6	4	0	0	2
2	***Contract provisions such as the imposition of a penalty during contract negotiations.***	7	4	2	1	4
3.5	***Procedures for administering claims for patients with third party coverage***	3	3	0	2	1
14	***Claims processing system configuration and web portal issues***	41	14	4	10	18
6	***Communication with CMO provider representatives and call center***	18	7	4	4	3
9	***Miscellaneous processing and confidentiality Issues***	4	1	0	1	3

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Category	**Summary Description of Issues and Concerns**	**Occurrence Count**	**Hospitals Commenting**	**Amerigroup**	**WellCare**	**Peach State**
3.8	***Coordination between CMO and outside/carve out vendors***	3	2	0	3	2
3.4	***Claims payment issues resulting from patients that switch between managed care and fee-for-service***	2	1	0	1	0
13	***Access, provider retention and acceptance of Medicaid beneficiaries***	2	1	0	0	0

Note 1) This table does not represent all issues and concerns from all hospitals. This list only represents a compilation of issues and concerns expressed to Myers and Stauffer LC.

Note 2) The issues and concerns as listed and described in this table have not been fully confirmed. The issues and concerns in this document are those expressed by providers that decided to submit information to Myers and Stauffer LC.

Note 3) The information in the table was last updated on November 13, 2007.

Confirmation of a Sample of Issues

In order to confirm a sample of the issues presented by the hospital providers, a series of meetings was held on November 7 and November 8, 2007. The meetings were held on the DCH premises and included hospital providers and the three CMOs.

Nine hospitals that had previously submitted information and supporting documentation for selected issues were asked to participate in a joint meeting with representatives from Myers and Stauffer LC and the CMO. The purpose of each joint meeting was to offer an opportunity for the hospital representative to have access to the CMO management in order to describe in detail the issue the provider was experiencing. The meetings also offered the opportunity for the CMO to respond to the hospital's issue, or to offer follow-up activities to help resolve the issue. Myers and Stauffer served as the meeting facilitator and observed the interaction to help us understand and confirm the hospital's concerns. The topics discussed were limited to the issue or concern that served as the purpose of the meeting.

Table 3, below, illustrates the participants of the November 7th and 8th meetings between hospitals and CMOs, a brief description of the issues discussed, as well as the status of the issue as of December 14, 2007.

Table 3: Summary of Meetings Between Hospitals and CMOs			
Hospital Provider	**CMO**	**Brief Description of Issue as Expressed to Myers and Stauffer**	**Status as of 12/14/2007**
Atlanta Medical Center	PSHP	CMO is not paying for metabolic screening add-on for newborns. CMO denies appeal and states claims paid appropriately.	Unresolved
Bacon County Hospital	WellCare	CMO is not paying for anesthesia professional fees billed for Certified Registered Nurse Anesthetists (CRNAs). Not all claims for emergency room professional fees are being paid. Claims were initially denied because provider was told physicians did not need a WellCare ID. Claims also denied because CMO stated the address in box 32 was wrong, as well as the wrong tax ID. There appears to be an issue with set up/contract loading since ER professional claims that say “Bacon County Community Care” (Not the correct name) are paid and claims that say “Bacon County Hospital” (Correct name) are denied.	Issues Resolved

Table 3: Summary of Meetings Between Hospitals and CMOs			
Hospital Provider	**CMO**	**Brief Description of Issue as Expressed to Myers and Stauffer**	**Status as of 12/14/2007**
Children's Healthcare of Atlanta	Amerigroup	CMO requires CPT identifiers on all outpatient claims for a broad list of revenue codes despite a smaller contracted list. Timeliness, including using admission date to start timeliness determination and short span of time allowed.	Issues Resolved
Children's Healthcare of Atlanta	PSHP	CMO denied ER claim that occurs within 48 hours of another ER claim, despite contract to the contrary.	Unresolved
Children's Healthcare of Atlanta	WellCare	CMO does not provide information regarding changes it makes to inpatient ICD diagnosis and procedure codes which result in a grouping to a different DRG CMO pays 75% of ER claims at triage rate then overturns 40% upon appeal. CMO does not consider the age of the patient, time of visit or combinations of diagnoses billed, including the admitting diagnosis. CMO will not incorporate findings from appeals process in updating process for paying ER claims	Resolved Unresolved
Fairview Park Hospital	PSHP	CMO pays a Medicaid short stay rate instead of a DRG rate as specified in the contract between the provider and CMO.	Unresolved

Table 3: Summary of Meetings Between Hospitals and CMOs			
Hospital Provider	**CMO**	**Brief Description of Issue as Expressed to Myers and Stauffer**	**Status as of 12/14/2007**
Floyd Medical Center	Amerigroup	CMO is using bundling and coding techniques contrary to those utilized by CMS and commercial payors.	Resolved
HCA - Georgia	WellCare	CMO utilizing short stay/transfer provisions instead of DRG rate even though this is not specified in the contract. CMO applying traditional outpatient (OP) caps even though there is no provision in the contract. CMO not paying for all non-listed labs and ambulatory charges at contract percentage rate.	Issues Unresolved
Henry Medical Center	PSHP	Claims not paid at contracted rates, including: Normal and C-Section deliveries, stop loss claims, outpatient claims, emergency room claims, observation claims, MRI/CT scans, false labor claims, and ASC claims.	All Issues Unresolved
John D. Archbold Memorial Hospital	PSHP	Labs are being reimbursed at the wrong percentage of the Medicaid Fee Schedule.	Unresolved
John D. Archbold Memorial Hospital	WellCare	CMO is not recognizing the presenting diagnosis on a claim as emergent. 80% of CMO triage payments are appealed with 60% being overturned upon appeal.	Unresolved

Table 3: Summary of Meetings Between Hospitals and CMOs			
Hospital Provider	**CMO**	**Brief Description of Issue as Expressed to Myers and Stauffer**	**Status as of 12/14/2007**
Phoebe Putney Memorial Hospital	PSHP	Provider's claims are not being paid according to the agreement with the CMO.	Unresolved

Summary notes from each of the meetings, including meeting participants, the topics of discussion and the current status of the issue, are included in Attachment C of this report. Recognizing that a comprehensive response to each issue would likely require the expertise of individuals not present during the meetings, we agreed that the CMOs could also provide follow-up information after the meetings. When available, this follow-up information from the CMOs is included in Attachment C.

While the notes from these meetings conducted between the hospital providers and the CMOs are reported in Attachment C, certain proprietary information or protected health information has been redacted from the notes. Care has been taken to ensure that the redactions do not diminish the provider's description of the issue(s) and the CMO's response(s).

The hospital providers and the CMOs were provided with draft copies of the meeting notes, and were afforded an opportunity to make comments and provide additional information regarding the notes included in the attachments to this report. Any subsequent activities or resolutions related to the issues discussed on November 7 and 8 that were not provided to Myers and Stauffer by December 14, 2007 have not been included in this report.

Conclusions

As described earlier in this report, the objective of the initial task of the engagement was to confirm the issues and concerns expressed by hospital providers regarding the adjudication of their GF claims and the transition to the care management organization delivery model. The communications that occurred during the meetings between the hospital providers and the CMOs, as well as the documentation submitted by hospitals, confirm the existence of multiple and significant issues with claim adjudication and transitional related matters. These issues include but are not limited to:

- Multiple claims adjudication and pricing issues
- Emergency room services payment and appeal issues
- Issues between hospital providers and CMOs regarding payment policies and contractual requirements
- Issues related to timeliness edits
- Procedural code policies and procedures
- DRG claim grouping issues including diagnosis code changes and sequencing
- Issues related to provider rate setups and identification of applicable provider groups associated with the hospital

Many of the issues reported by hospitals are unique occurrences between hospitals and the CMOs. However, there are certain issues that appear to be pervasive issues impacting multiple hospitals.

These include but are not limited to:

(1) Emergency room claim payment issues;
(2) Pre-certification issues;
(3) Timeliness edit issues; and
(4) Provider setup issues.

Other observations:

- Based on our discussions with CMOs and hospitals, we note that some hospital-related issues are beginning to be addressed, and in some cases resolved by the CMOs.

- Two issues brought to our attention by the hospitals had been resolved prior to the November 7 and 8, 2007 meetings. Resolution of these two issues occurred as a result of contract renegotiations and thus a change in contract requirements.

- Several issues brought to our attention have been partially resolved. For example, a hospital provider may have alleged that the claims processing system for a particular CMO was not correctly adjudicating certain types of claims. If the CMO corrected the claims processing system but did not reprocess the claims that were inappropriately paid while the system was not operating correctly, we consider the issue to be unresolved.

- It appears that ambiguity in contract language between the hospital providers and CMOs may have accounted for a significant number of the hospital issues. It appears that the ambiguity in some contracts has lead to differences in interpretation of the contract and in payment expectations.

- One hospital provider selected to participate in the November 7 – November 8, 2007 meetings has terminated their contract with a CMO due to the inability of the CMO and provider to reach an agreement regarding bundling and coding procedures.

- One CMO reported to Myers and Stauffer LC that after system corrections are made they do not reprocess affected claims from all providers. This CMO indicated that changes are only applied to providers that contact them regarding particular issues.

Contributing Factors

Myers and Stauffer LC observed several factors that may have contributed to the issues occurring since implementation of the Georgia Families program. Please note that not every factor is relevant to every hospital provider or CMO.

- The Georgia Families program transitioned approximately one million Medicaid and PeachCare for Kids™ members into a care management model over a four-month period. While case management, disease management, and other somewhat similar programs have existed in Georgia for many years, the full-risk Medicaid care management model was new to most hospital providers and Medicaid and PeachCare for Kids™ members in Georgia. The large volume of members transitioned into managed care plans, as well as the number of involved providers, appears to have created challenges and capacity issues for CMOs and hospitals alike.

- During the course of our analysis of hospital provider issues and concerns, it appears that certain hospital providers may not have performed an exhaustive review of their contracts with the CMOs. While Contract terms should be fully described within the four corners of the contract, based on input we received, it appears that some hospitals have instead made some assumptions regarding contract terms that were not explicit, and those assumptions were not shared by the CMO.

- Familiarity with Georgia hospitals – Discussions with hospitals and CMOs appear to indicate that the CMOs' lack of familiarity with Georgia hospitals may have contributed to many of the contracting and provider setup issues. Many hospitals have physician groups and other unique hospital billing situations that should have been addressed by both the CMOs and hospitals during the contract negotiation phase.

- CMO staff and management turnover – We observed turnover in the staff and management of two of the three CMOs during the course of our hospital provider issue analysis occurring between September and November 2007. Hospital providers also reported that turnover has occurred frequently among the CMO provider relations staff, contributing to delays in resolving issues throughout the implementation and transition to the Georgia Families program.

- It is appears that many of the issues and concerns expressed by hospitals are related to communication issues between the CMO and the hospital. Hospitals reported to us that their issues began to be addressed after they were able to connect with the appropriate CMO representative, typically CMO management.

Next Steps

As stated earlier, the scope of this interim report is limited to analyzing and summarizing a sample of the concerns reported to Myers and Stauffer LC by Georgia hospital representatives. Ongoing and upcoming activities will provide additional information and insight regarding the implementation and operation of the Georgia Families program. These activities include but are not limited to the following:

- An analysis of the pricing and adjudication of hospital claims
- The accuracy and length of time required to complete hospital rate loads
- The length of time required to complete hospital credentialing
- An analysis of denied and suspended hospital claims
- An analysis of provider participation
- An analysis of pre-certification approvals and denials
- A comparison of selected operational and administrative policies to those used in other State Medicaid managed care programs

The results of the above activities will be included in subsequent reports for this phase of the engagement. We also anticipate extending analytical and research activities to additional provider types in the coming weeks.

Attachment A **Hospital Issues and Concerns Reported to Myers and Stauffer**

Information Current As of November 13, 2007

Note 1) This document is not intended to imply that this list represents the universe of issues and concerns from all hospitals. This list represents a compilation of issues and concerns expressed to M&S beginning in September 2007. Hospitals decided whether to submit issues and concerns to M&S.

Note 2) This document is not intended to imply that this list represents the universe of issues and concerns from the providers that decided to submit information to M&S.

Note 3) The issues and concerns in this document are those expressed by providers that decided to submit information to M&S.

Source Key

A *Memorandum from Department of Community Health to Board of Community Health dated 9/13/07*
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Category	Item #	Concern Narrative as Expressed by Hospitals to Myers and Stauffer	Source	Specific CMO, if indicated	Provider
1	1	Local CMO representatives (including the local presidents) are not empowered to resolve issues - decisions made at a corporate (national) level may not take into consideration unique local situations and/or factors.	*A,B*		
1	2	State CMO officials and provider representatives do not have the ability to address problems at the local level.	*B*		
1	3	Local CMO representative cannot resolve issues - must be referred to corporate level	*C - HH*	Peach State	Archbold
1	4	Because things are so centralized outside of the state, PSHP cannot answer questions	*C - HH*	Peach State	N.GA Med. Ctr
1	5	CMO staff available via telephone are not empowered to facilitate resolution of issues.	*C,D-CHOA*		CHOA
1	6	No authority to resolve issues given to personnel at local level.	*F*		Oconee Regional Medical Center
2	7	Imposition of 10% penalty during contract negotiations. Providers are paid 90% of Medicaid by CMO while in the negotiation stages for their contract.	*C - VHA*	Amerigroup, Peach State	
2	8	Confusion and changing requirements during contracting process regarding hospital based physicians	*C-GHA*	Amerigroup	Dodge County Hospital
2	9	Contract allows provider to bill patient for services that CMO has determined as not medically necessary, however, Explanation of Payments are indicating not patient's responsibility	*D-Tanner*	WellCare	Tanner Health System
2	10	Contract specifically prohibits provider from billing patient for services that CMO has determined as not medically necessary. Provider disagrees with this provision.	*D-Tanner*	Peach State	Tanner Health System
2	11	CMO believes that the treatment of certain conditions is not a covered diagnosis under their contract	*D-Tanner*	Peach State	Tanner Health System
2	12	Imposition of 10% penalty during contract negotiations. Providers are paid 90% of Medicaid by CMO while in the negotiation stages for their contract.	*F*	Peach State	Colquitt Regional Medical Center

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2	315	CMO is assessing $12.50 co-payment for pregnant women contrary to DCH policy.	*C*	Amerigroup	University Hospital
3.1	13	Implants are being carved out but there is no contract provision for this carve-out	*C - HH*	Peach State	Archbold
3.1	14	CMO requires implant invoices to reprocess the implant charge on a claims even though contract does not state that implants are to be reimbursed at cost	*F*	Peach State	HCA Georgia (14 facilities)
3.1	15	CMO applies Medicaid outpatient (OP) maximum cap to OP services although this is not specified in contract. Contract states that any conflict between Provider Handbook and the contract will be controlled by the contract.	*C - HH*	Peach State	Fairview Park
3.1	16	CMO applying traditional Medicaid OP caps even though there is no provision in contract.	*F*	WellCare	HCA Georgia (14 facilities)
3.1	17	CMO not paying for all non-listed labs and ambulatory charges at contract percentage rate.	*F*	WellCare	HCA Georgia (14 facilities)
3.1	18	CMO's are failing to pay a significant percentage of claims in accordance with the provider contracts they negotiated.	*A,B*		
3.1	19	CMOs have not received, from DCH, reference data regarding the percentage of claims paid accurately by the CMOs, in compliance with the terms of their provider contracts.	*B*		
3.1	20	CMO not correctly paying the facility fee claims for a hospital based clinic as contract states.	*C - HH*	WellCare	N.GA Med. Ctr
3.1	21	CMO pays a Medicaid short stay rate instead of a DRG rate as specified in their contract.	*C - HH*	Peach State, WellCare	Fairview Park
3.1	22	CMO paying/utilizing short stay/transfer provision instead of DRG rate even though this is not specified in contract	*F*	WellCare	HCA Georgia (14 facilities)
3.1	23	CMO does not pay based on contracted rates	*C - VHA*	WellCare	Houston Healthcare
3.1	24	CMO denies ER claim that occurs within 48 hours of another ER claim, despite contract to the contrary	*C,D-CHOA*	Peach State	CHOA
3.1	25	Normal delivery and C-section paid at DRG instead of case rate per contract	*C-GHA*	Peach State	Henry Medical Center
3.1	26	Stop loss not paid according to contractual 1st dollar provision	*C-GHA*	Peach State	Henry Medical Center
3.1	27	OP claims not paid according to HMC's CCR	*C-GHA*	Peach State	Henry Medical Center
3.1	28	ER claims not paid at correct level per HMC contract	*C-GHA*	Peach State	Henry Medical Center

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3.1	29	Observation claims not paid according to case rate per contract	*C-GHA*	Peach State	Henry Medical Center
3.1	30	False labor - nongroupable ASC and groupable ASC - not paid according to case rate	*C-GHA*	Peach State	Henry Medical Center
3.1	31	MRI's & CT's paid by percent of charges instead of case rate	*C-GHA*	Peach State	Henry Medical Center
3.1	32	Claim denies for "charge exceeds allowable amount" when payments are based upon a predetermined contractual schedule - regardless of the amount billed.	*E*	Amerigroup	Murray Medical Center
3.1	33	Claims are not being paid according to contract agreement based on the facility.	*F*	WellCare	Piedmont Healthcare
3.1	34	Provider physician group is being paid less than their contracted rates.	*F*	WellCare	Memorial Health University Medical Center (Physicians Group)
3.1	35	Recouping payment for services when patient eligibility was verified by CMO. Contract states such recoupments are not permitted when the "payor's employees or agents erroneously verify a covered patient's eligibility."	*F*	Peach State	Sumter Regional Hospital
3.1	36	Claims are not being paid according to contract agreement based on the facility.	*F*	Peach State	Phoebe Putney Memorial Hospital
3.1	317	CMO paying CPTs by fee schedule rate not equal to base traditional Medicaid rate/interim outpatient rate (IOR) percentage.	*C*	Amerigroup	University Hospital
3.2	37	CMOs are using bundling and coding techniques contrary to those utilized by CMS and commercial payors with the sole intent of reducing reimbursement.	*C - VHA*	Amerigroup, Peach State	
3.2	38	CMO requires CPT identifiers on all OP claims for a broad list of revenue codes despite smaller contracted list	*C,D-CHOA*	Amerigroup	CHOA
3.2	39	CMO denies claims stating it requires a surgical charge be billed with a valid CPT/HCPCS. Claim includes valid code.	*F*	Peach State	HCA Georgia (14 facilities)
3.2	40	CMO requires that certain claims be filed on UB with different CPT codes than are required by Medicaid and the other CMO's	*D-Tanner*	Amerigroup	Tanner Health System
3.2	41	CMO and provider disagree on the appropriate coding for the medical records for Neonatal Hypermagnesemia. CMO says only one code should be used on claim, provider confirmed with AHA the appropriateness of using 2 codes	*F*	WellCare	Memorial Health University Medical Center

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3.2	42	Claims are being denied or being partially paid for invalid procedure codes when valid codes are on the UB (Deliveries)	*F*	WellCare, Peach State	Northside Hospital
3.2	43	CMO denies revenue code 260 (IV Therapy), requiring a CPT/HCPCS code to break down each item under revenue code 260.	*F*	Peach State	Phoebe Putney Memorial Hospital
3.2	44	CMOs are using bundling and coding techniques contrary to those utilized by CMS and commercial payors.	*F*	Amerigroup	Floyd Medical Center
3.3	45	Denying claims as global when a UB and a 1500 for the same tax ID is used	*C - HH*	Peach State	Flint River
3.3	46	CMO not paying for non-listed labs and ambulatory charges at the contract percentage rate due to "global fee" being applied.	*F*	Peach State	HCA Georgia (14 facilities)
3.3	47	CMO is denying anesthesia claim stating this is paid under global charge to surgeon	*C - HH*	Peach State	Upson
3.4	48	Patients can and do change CMO's during an inpatient stay which raises many payment issues. Standard rules should be developed to ensure providers receive payment for medically necessary services provided to the payments.	*A,B*		
3.4	49	Provider not getting paid for certain services when patient switches from CMO to FFS Medicaid, especially when length of stay spans both eligibilities. Services not covered consistently between 2 payors.	*D-Tanner*	WellCare	Tanner Health System
3.5	50	CMO denies all claims with potential third party liability. In order to get reimbursed as required by DCH after claim remains unpaid for 60 days, CHOA must appeal the payment.	*C,D-CHOA*	WellCare	CHOA
3.5	51	Use of TPL vendor to retrospectively recover "possible" payments due from primary carriers.	*F*	WellCare	Oconee Regional Medical Center
3.5	52	CMO had information regarding other primary insurance for a beneficiary that did not appear on the State's website but did not provide the information to the provider.	*F*	Peach State	Phoebe Putney Memorial Hospital
3.6	53	Deny payment for pneumococcal and flu vaccines delivered in OP setting even though it is covered and contracted service	*C,D-CHOA*	WellCare, Peach State	CHOA
3.6	54	Denies payment for Synagis when provided in an outpatient setting despite covered, authorized service	*C,D-CHOA*	Peach State	CHOA
3.7	55	Provider informed not to contract hospital based providers but now CMO will not pay for claims	*C - HH*	Amerigroup	Flint River
3.7	56	Denying hospital claims stating that physician who admitted patients to the hospital was not in network. Hospital is in network.	*C - HH*	Peach State	Flint River
3.8	57	Do not effectively coordinate claims payments between the CMO and their designated psychiatric carve-out vendor	*C,D-CHOA*	WellCare, Peach State	CHOA

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3.8	58	Do not effectively coordinate claims payments between the CMO and transplant carve-out vendor	*C,D-CHOA*	WellCare	CHOA
3.8	59	Confusion about responsibility for payment of labs associated with behavior health treatment.	*D-Tanner*	WellCare, Peach State	Tanner Health System
3.9	60	Provider should not have to request the outlier payment.	*C - VHA*		
3.9	61	Delays in loading or correcting provider files including fees schedules	*C,D-CHOA*		CHOA
3.9	62	CMO does not provide information regarding changes it makes to inpatient ICD diagnosis and procedures codes which result in a grouping to a different DRG than anticipated.	*C,D-CHOA*	WellCare	CHOA
3.9	63	Delays in processing outlier payments or outlier approved but never paid	*C,D-CHOA*	Peach State, WellCare, Amerigroup	CHOA
3.9	64	CMO requires provider to appeal inlier payment in order to receive outlier payment. Requires excesses amount of time to review outlier requests.	*F*	Peach State	HCA Georgia (14 facilities)
3.9	65	Payer method of responding to billed claims does not provide information providers need to track claims	*D-Tanner*	Peach State, WellCare, Amerigroup	Tanner Health System
3.9	66	A high percentage of claims either have been or are awaiting reprocessing by the CMO's for unknown reasons.	*F*		Oconee Regional Medical Center
3.9	67	CMO constantly changes guidelines, requiring frequent staff retraining in order to avoid losing reimbursement.	*F*	Peach State	Phoebe Putney Memorial Hospital
3.9	68	CMO denying claim for misleading and incorrect denial reason code on Explanation of Benefits.	*F*	Peach State	Phoebe Putney Memorial Hospital
3.9	69	Home Health claims incorrectly denying for duplicate when provider is trying to resubmit to correct previous denial issues.	*F*	Peach State	DeKalb Medical Center
3.9	70	No claims for anesthesia professional fees are being paid by CMO. Denied codes are NOFEE (procedure code not on your fee schedule) and DN025 (no contractual fee allowance).	*F*	WellCare	Bacon County Hospital
3.9	316	Outpatient claims not paying according to Letter of Agreement (LOA) fee schedule.	*C*	Amerigroup	University Hospital
3.91	71	Base rate portion of DRG payment system has never been properly inflated.	*C - HH*	Peach State	Archbold
3.91	72	Labs are being reimbursed at the wrong percentage of the Medicaid fee schedule	*C - HH*	Peach State	Archbold
3.91	73	Errors in payments and recoupments.	*C - HH*	WellCare	Archbold

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3.91	74	Having difficulty paying when multiple procedures are performed during the same operative session and two are bilateral procedures. Difficulty with bilateral modifiers	*C,D-CHOA*	Peach State, WellCare, Amerigroup	CHOA
3.91	75	Outpatient claims were not paid per the Medicaid's fee schedule percent of charges rate	*C-GHA*	Amerigroup	Henry Medical Center
3.91	76	DRG claims not reimbursed per the Medicaid fee schedule	*C-GHA*	Amerigroup	Henry Medical Center
3.91	77	IP claims not paid at per diem rate for Med Surg CCU and ICU	*C-GHA*	Peach State	Henry Medical Center
3.91	78	Inconsistent payment of claims by CMO	*F*	WellCare	Memorial Health University Medical Center
3.91	79	CMO does not calculate reimbursement for observation claims accurately (should be XX% of charges)	*F*	Peach State	West Georgia Health System
3.91	80	Provider believes that CMO should pay for metabolic screening add-on for newborns. CMO denies appeal and states claim paid appropriately	*F*	Peach State	Atlanta Medical Center
3.91	81	CMO fails to pay DRG rates per DCH, instead they are paying total charges	*F*	Amerigroup	Memorial Health University Medical Center
4	82	Hospitals and other providers are routinely denied payments for medically necessary services because of situations beyond the provider's control.	*A,B*		
4	83	Concern that CMOs are committing sufficient resources to actively manage the care of their enrollees.	*A,B*		
4	84	Failure to commit sufficient resources to manage the care of enrollees.	*F*	WellCare, Peach State	Sumter Regional Hospital
4	85	It is also unclear how the effectiveness of the CMO's case management activities is being evaluated and measured.	*A,B*		
4	86	CMOs have not provided data to support the effectiveness of their disease management or case management efforts.	*B*		
4	87	CMOs have not provided data to show decreases in inappropriate utilization of emergency room services across the state	*B*		

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4	88	CMOs have not provided data to demonstrate that there has been any reduction in unnecessary utilization of services by CMO enrollees or any improvement in the quality of care.	*B*		
4	89	Savings to Medicaid program are attributable to the denial of claims by CMOs rather than case management and member education.	*B*		
4	90	CMOs are using criteria that are not clinically supported to deny medically necessary services and the lack of uniform criteria is resulting in inconsistent medical necessity determinations.	*B*		
4	91	No evidence of case management with CMOs not managing patients due to staffing issues.	*C - HH*	Peach State, WellCare	Archbold
4	92	CMO utilization management requirements are inconsistent with industry standards. Frequency and duration of concurrent and peer reviews far exceeds industry standards.	*D-Tanner*	Peach State, WellCare, Amerigroup	Tanner Health System
4	93	The CMO's are not using nationally standardized medical necessity criteria	*D-Tanner*	Peach State, WellCare, Amerigroup	Tanner Health System
4	94	CMO's are not abiding by their own medical necessity criteria as it is currently written	*D-Tanner*		Tanner Health System
4	95	CMO's refuse attempts by Tanner to utilize specialty medical necessity criteria in utilization management	*D-Tanner*	Peach State, WellCare, Amerigroup	Tanner Health System
4	96	Provider believes CMO's are denying access to psychiatric.	*D-Tanner*	WellCare, Peach State	Tanner Health System
4	97	CMO denies or limits access to court-mandated treatment for children or adolescents	*D-Tanner*	WellCare	Tanner Health System
4	98	Delays with carrier call backs related to requests for the name of a "Preferred MD", needed in order to discharge a patient, causing delays in discharging patients.	*F*	Peach State, WellCare, Amerigroup	Northside Hospital
5	99	CMO states that PA is not required and then payment is denied due to lack of PA.	*C - HH*	Amerigroup	N.GA Med. Ctr
5	100	Cannot get updated PA list from CMO	*C - HH*	Amerigroup	N.GA Med. Ctr
5	101	Had negotiated rates based upon no authorization and claims denied for no PA	*C - HH*	WellCare	N.GA Med. Ctr
5	102	CMOs are inconsistently denying or paying claims for labor checks performed by hospitals. Some are denied for no authorization and should not require authorization.	*C - VHA*		

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5	103	CMO do not publish a list of CPT codes that require prior authorization.	*C - VHA*		
5	104	Prior authorization is required for all inpatient and outpatient services, except outpatient laboratory services	*C,D-CHOA*	WellCare	CHOA
5	105	Failure to coordinate web site provider information with adjudication system in regards to whether specific procedures require PA (for instance, Gardasil (HPV))	*F*	WellCare	Sumter Regional Hospital
5	106	No list of individual CPT codes requiring prior authorization provided	*C,D-CHOA*	Peach State, WellCare, Amerigroup	CHOA
5	107	CMO medical management indicates that no PA is required then claim denies for failure to authorize	*C,D-CHOA*	Peach State, WellCare, Amerigroup	CHOA
5	108	CMO medical management refuses to provide PA for services despite fact that service requires PA	*C,D-CHOA*	Peach State, WellCare, Amerigroup	CHOA
5	109	Payment is denied for services that do not require PA for failure to authorize.	*C,D-CHOA*	Peach State, WellCare, Amerigroup	CHOA
5	110	PA is specific to the CPT codes built into the PA. Only exact matches pay. PA for families of codes is limited to radiological services.	*C,D-CHOA*	Amerigroup, WellCare	CHOA
5	111	CMO requires providers to contact CMO by end of next business day to add-on procedures for a PA already issued.	*C,D-CHOA*	WellCare, Peach State	CHOA
5	112	CMO will not revise a PA for add-on procedures. Provider must appeal all resulting claim payment denials	*C,D-CHOA*	Amerigroup	CHOA
5	113	Claims combined under the Medicaid 72 hour rule have separate PA's. Must contact CMO to combine the PA records so that claim will not deny.	*C,D-CHOA*		CHOA
5	114	Claims with valid PA's are denying because of moving the PA from the medical management system to the claims payment system.	*C,D-CHOA*	Peach State	CHOA
5	115	Claims processing system is programmed to look for PA's for some CPT/HCPCS and revenue code combinations for which the medical management team indicates PA is not required.	*C,D-CHOA*	Amerigroup	CHOA
5	116	Transfer babies denied for no precertification	*C-GHA*	WellCare	Henry Medical Center

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5	117	PA's are not received in a timely manner, usually > 14 days	*F*	WellCare, Peach State	Memorial Hospital and Manor Bainbridge
5	118	Services denied as unauthorized in error. Authorization is on file with payer but provider must call to have PA recognized and claim re-processed.	*D-Tanner*	Peach State, Amerigroup	Tanner Health System
5	119	The requirement for re-authorization of treatment plans established under Medicaid was not clearly communicated resulting in "unauthorized service" denials	*D-Tanner*	Peach State, WellCare, Amerigroup	Tanner Health System
5	120	Authorizations loaded by payer with inaccurate dates resulting in treatment days being denied in error	*D-Tanner*	Peach State	Tanner Health System
5	121	Authorizations loaded by payer with inaccurate provider tax ID resulting in denials and additional calls to resolve claim by payer.	*D-Tanner*	Peach State	Tanner Health System
5	122	Physician office and Piedmont Healthcare Facilities are told no PA is required for a procedure and the claim is later denied stating authorization was required.	*F*	WellCare	Piedmont Healthcare
5	123	Claims are denying stating that authorization was not obtained in a timely manner (within 24 hours of inpatient admission)	*F*	WellCare	Piedmont Healthcare
5	124	Emergency department claims are denied for lack of precertification	*F*	WellCare	Memorial Health University Medical Center
5	125	Denials caused by inconsistent policy interpretation and application, such as, precertification denials	*F*	Amerigroup, WellCare	Oconee Regional Medical Center
5	126	CMOs are requiring notification within 24 hours of an observation or inpatient admission - including weekends.	*F*	WellCare	Colquitt Regional Medical Center
5	127	CMO sent letter dated 6/13/06 stating that for unplanned and urgent admissions, providers have until the next business day to obtain prior authorization. Claims are still being denied despite presenting this letter with the appeals.	*F*	WellCare	WellStar
5	128	CMOs are inconsistently denying or paying claims for labor checks performed by hospitals. Some are denied for no authorization and should not require authorization.	*F*		Colquitt Regional Medical Center
5	129	CPT code J0881 denies for lack of authorization but is not listed on Specialty Injectable Drugs list	*F*	Peach State	Phoebe Putney Memorial Hospital
5	130	CMO denies payment for short stay OB claims (defined as 2 days or less for vaginal, 4 days or less for c-section) for no authorization when authorization is not required for these short stays.	*F*	Peach State	DeKalb Medical Center

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5	131	Newborns receiving multiple authorization numbers, one at birth and another when mother adds baby to policy	*F*	Peach State	DeKalb Medical Center
5	132	Provider experiences delays in precertification notices that results in claims being denied because the service was authorized at a lower level of care than the provider requested/provided.	*F*	Peach State	Gwinnett Medical Center
5	133	Entire claim denies for no prior authorization when baby stayed 5 nights instead of 4 that was authorized.	*F*	Peach State	West Georgia Health System
5	134	CMO requirement for authorization of all routine radiological procedures is excessive.	*F*	WellCare	Gwinnett Medical Center
5	318	Claim denied for no authorization yet per CMO, no auth required	*C*	Amerigroup	University Hospital
5	319	Claims inappropriately denied for no authorization	*C*	Amerigroup	University Hospital
6	135	CMO representatives often reference policies and procedures that conflict specific contract terms.	*A,B*		
6	136	CMOs have not provided data regarding the percentage of calls that are answered accurately by their call center staff or by their provider representatives.	*B*		
6	137	CMO call centers and provider representatives give inconsistent responses to questions.	*B*		
6	138	Minimal to nonexistent contact with local representatives, representatives do not return phone calls or emails in a timely manner	*C - HH*	WellCare	Archbold
6	139	CMO can't find clinical documentation that provider has fax confirmation for, makes provider resend. Takes 4-5 days to get a response.	*C - HH*	Amerigroup	N.GA Med. Ctr
6	140	Fax number for sending birth notifications was incorrect on CMO form	*C - HH*	Peach State	Archbold
6	141	No confirmation of receipt for fax for prior authorizations.	*F*	WellCare, Peach State	Memorial Hospital and Manor Bainbridge
6	142	No identified process for getting authorizations to treat in an urgent situation.	*F*	WellCare, Peach State	Memorial Hospital and Manor Bainbridge
6	143	Poor follow up and communications	*C - HH*	Amerigroup	N.GA Med. Ctr
6	144	CMO staff give inconsistent information regarding prior authorization requirements.	*F*		Memorial Hospital and Manor Bainbridge
6	145	CMO does follow up but it take a long time to get things resolved	*C - HH*	WellCare	N.GA Med. Ctr

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6	146	CMO makes changes/updates to manuals with notifying the providers	*C - VHA*	WellCare, Peach State	Houston Healthcare
6	147	CMO manuals do not match their internal policies on coverage, precerts, etc.	*C - VHA*	WellCare, Peach State	Houston Healthcare
6	148	CMO does not notify provider of changes related to UR nurse resulting in need for provider to fax clinical data multiple times.	*F*	Peach State	West Georgia Health System
6	149	CMO staff give inconsistent information regarding the filing for and payment of outliers.	*C - VHA*		
6	150	Provider calls payer re: unpaid claim. Payer responds "no claim on file." Claim is paid within 2 weeks without an additional claim submission	*D-Tanner*	Amerigroup	Tanner Health System
6	151	Must submit appeal documentation numerous times in order to get a response.	*F*	Peach State	West Georgia Health System
6	152	CMO staff give inconsistent information regarding the filing for and payment of outliers.	*F*	Amerigroup	Floyd Medical Center
7	153	Conflicting information regarding eligibility between the State's website and the CMO's website.	*C - VHA*		
7	154	Conflicting information regarding eligibility between the State's website and the CMO's website.	*F*	Peach State	WellStar
7	155	Newborn ID issued by State and then a different ID for same newborn issued by CMO.	*C - VHA*	Amerigroup	
7	156	CMO recoups payments for patients they say are ineligible when the State's website and the CMO's website clearly indicate they are eligible.	*C - VHA*	WellCare	
7	157	Newborn enrollment in CMO is delayed.	*C,D-CHOA*		CHOA
7	158	Newborn Medicaid eligibility is taking 45-60 days to convert to the mother's CMO. Cannot bill until eligibility is present.	*F*	Amerigroup	Atlanta Medical Center
7	159	Duplicate member records or erroneous CMO member enrollment (for children enrolled in SSI)	*C,D-CHOA*		CHOA
7	160	Changes in Medicaid enrollment during a continuous inpatient stay	*C,D-CHOA*		CHOA
7	161	GHP web portal suggests that child is enrolled in both traditional Medicaid and in a CMO	*C,D-CHOA*		CHOA
7	162	Initial eligibility shows FFS Medicaid, however, when it is later determined that the eligibility was actually with the CMO, the CMO denied the claim for late notification or lack of precertification	*F*	WellCare	Memorial Health University Medical Center
7	163	CMO denies claim for timeliness when eligibility data is uploaded in an untimely manner.	*F*	Peach State	Atlanta Medical Center

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7	164	Conflicting information regarding eligibility between the State's website and the CMO's website.	*F*	WellCare, Peach State	Colquitt Regional Medical Center
7	165	CMO recoups payments for patients they say are ineligible when the State's website and the CMO's website indicate they are eligible.	*F*		Colquitt Regional Medical Center
7	166	Conflicting information regarding eligibility between the State's website and the CMO's website.	*F*		Floyd Medical Center
7	167	CMO recoups payments for patients they say are ineligible when the State's website and the CMO's website clearly indicate they are eligible.	*F*	WellCare	Floyd Medical Center
8	168	CMOs have not provided data regarding the percentage of their initial claims payments that are appealed by providers	*B*		
8	169	CMOs have not provided data regarding the percentage of appealed claims payments that are overturned.	*B*		
8	170	The additional resources required to handle the volume of appeals and underpayments has placed an undue financial burden on the hospitals.	*C - VHA*		
8	171	The additional resources required to handle the volume of appeals and underpayments has placed an undue financial burden on the hospitals - most are no-precert appeals.	*F*		WellStar
8	172	The additional resources required to handle the volume of appeals and underpayments has placed an undue financial burden on the hospitals.	*F*	WellCare	Colquitt Regional Medical Center
8	173	Significant denials for no prior authorization - upon appeal, claim is overturned and paid.	*F*		Atlanta Medical Center
8	174	The additional resources required to handle the volume of appeals and underpayments has placed an undue financial burden on the hospitals.	*F*	WellCare, Peach State	Phoebe Putney Memorial Hospital
8	175	Providers should not have to appeal underpayments nor have time restrictions imposed on requesting the additional payment.	*F*	Peach State	Phoebe Putney Memorial Hospital
9	176	Provider receiving payments that do not belong to their facility	*C - HH*	Peach State	Archbold
9	177	Received Explanation of Payment with other facility patients	*C - HH*	WellCare	Archbold
9	178	Cenpatico checks being sent to wrong providers not associated with hospital	*C - HH*	Peach State	Archbold
9	179	CMO violated contract confidentiality by including contract terms from an unrelated hospital in correspondence to Archbold	*C - HH*	Peach State	Archbold
10	180	All three of the CMO's have failed to properly load numerous providers (physicians, clinics, etc.) into their systems, in many cases even one year after contracts were signed.	*A,B*		
10	181	CMO's too often fail to credential providers in a timely manner and to load provider information accurately into their systems.	*A,B*		

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10	182	CMOs have failed to load provider agreements into their systems even a year after the contracts were signed.	*B*		
10	183	Failure to properly load physicians into provider database.	*F*	WellCare, Peach State	Sumter Regional Hospital
10	184	Physician and mid-level providers not loaded from initial start-up.	*C - HH*	Peach State, WellCare	Archbold, Dodge
10	185	Cenpatico contract not loaded because Cenpatico has issues with contract language	*C - HH*	Peach State	Archbold
10	186	CMOs do not pay physicians for medically necessary services they provide until the credentialing process is complete. Medicaid would pay for claims for services provided from the time the application was made.	*C - VHA*		
10	187	Credentialing of physician has been in process for 10 months and is still not complete.	*C-GHA*	WellCare	Amy Clemons MD
10	188	Credentialing of physician has been in process since September 2006 and is still not complete.	*C-GHA*	Amerigroup	Hugh Kyle Parks, MD
10	189	CMO did not load contract until 6 weeks after contract start date. Claims received during that time period were not recognized. When follow up was done with the CMO, the claims were denied for untimely filing.	*D-Tanner*	Amerigroup	Tanner Health System
10	190	Took nine months to get credentialing process completed for one MD. CMO's have requested unique CPT billing by this provider.	*D-Tanner*	WellCare, Peach State	Tanner Health System
10	191	Numerous physicians are still pending issuance of CMO ID numbers	*F*	WellCare	Memorial Health University Medical Center (Physicians Group)
10	192	CMOs do not pay physicians for medically necessary services they provide until the credentialing process is complete. Medicaid would pay for claims for services provided from the time the application was made.	*F*	WellCare, Peach State	Colquitt Regional Medical Center
10	193	CMO's fail to credential providers in a timely manner and to load provider information accurately into their systems.	*F*	Peach State	Phoebe Putney Memorial Hospital
10	194	CMO incorrectly loaded DeKalb OP rate for the recently opened Hillandale campus.	*F*	Peach State	DeKalb Medical Center
10	195	CMO has not reconciled a recoupment due to errors in loading initial rates.	*F*	Peach State	DeKalb Medical Center

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10	196	Not all claims for ER professional fees are not being paid. Claims were initially being denied because provider was told physicians did not need WellCare ID but they did. Then claims denied because WellCare stated the address in box 32 was wrong, as well as the wrong tax ID.	*F*	WellCare	Bacon County Hospital
10	197	Appears to be issue with set up/contract loading since ER professional claims that say "Bacon County Community Care" (NOT the correct name) are paid and claims that say "Bacon County Hospital" (correct name) are denied.	*F*	WellCare	Bacon County Hospital
11	198	Some CMO's are basing hospital claims submission timeliness on admission date, not discharge date.	*A,B*		
11	199	The CMO's often fail to comply with section 4.16.1.13 of the DCH - CMO contract which sets forth requirements related to the timely filing of claims by denying claims when the CMO, rather than the provider, was responsible for the filing error.	*A,B*		
11	200	Denying claims as untimely at XXX days when contract states XXX days.	*C - HH*	Peach State	Flint River
11	201	Secondary claims being denied due to timely filing when this is not the case	*C - HH*	Peach State	Archbold
11	202	CMO denies nonparticipating provider claims as untimely when provider should have 365 days to bill	*C - HH*	Amerigroup	Flint River
11	203	CMOs are requiring notification within 24 hours of an observation or inpatient admission - including weekends.	*C - VHA*	WellCare and Peach State	
11	204	Providers are being penalized by having entire claim denied when member does not present CMO ID card upon admission, resulting in provider failing to notify CMO within 24 hours of admission.	*F*	WellCare	West Georgia Health System
11	205	CMO manuals state that the provider has 365 days from the date of service to file a claim where the CMO is the secondary payor but CMO is only allowing 180 days for timely filing	*C - VHA*	WellCare, Peach State	Houston Healthcare
11	206	Providers must "appeal" a claim that is underpaid within 45-90 days time period is unreasonably short given that overpayments can be recouped with no such time limits.	*C - VHA*		
11	207	Providers must "appeal" a claim that is underpaid within 45-90 days time period is unreasonably short given that overpayments can be recouped with no such time limits.	*F*	Amerigroup	WellStar
11	208	The appeals timelines should be waived for the first year of start up given the enormous volume of denials and underpayments	*C - VHA*	Amerigroup, Peach State	
11	209	Use date of admission rather than date of discharge to determine whether a claim was received timely	*C,D-CHOA*	Amerigroup, WellCare	CHOA
11	210	CMO's have extremely short time frames for appealing claim errors (maximum 90 days) and are especially unrealistic given the volume of variances.	*C,D-CHOA*		CHOA

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11	211	Timely filing limit is 120 days whereas other CMOs and Medicaid is 180 days	*D-Tanner*	Amerigroup	Tanner Health System
11	212	Amerigroup and Cenpatico (PSHP) timely denial response period is 45 days. Medicaid and WellCare denial response period is 90 days	*D-Tanner*	Amerigroup, Peach State	Tanner Health System
11	213	Claims are denying for untimely appeals. Provider has 90 days to appeal.	*F*	WellCare	Piedmont Healthcare
11	214	Retro-denials for any number of reasons that cannot be appealed by provider because of timeliness restrictions.	*F*	WellCare	Oconee Regional Medical Center
11	215	Both the website functionality and the high percentage of claims reprocessed negatively impact the provider's ability to meet timeliness criteria	*F*		Oconee Regional Medical Center
11	216	The appeals timelines should be waived for the first year of start up given the enormous volume of denials and underpayments	*F*		Colquitt Regional Medical Center
11	217	Newborn baby claims are being denied when billed with the mother's ID and authorization number. When the baby's ID number is given and the claim is rebilled as requested by the carrier, then the claim is denied for untimely filing.	*F*	Peach State, WellCare, Amerigroup	Northside Hospital
11	218	Carriers are requesting additional documentation or claim corrections, then inaccurately denying the claim as untimely even though the information is furnished in a timely fashion	*F*	Peach State, WellCare, Amerigroup	Northside Hospital
11	219	The appeals timelines should be waived for the first year of start up given the enormous volume of denials and underpayments	*F*	WellCare, Peach State	Phoebe Putney Memorial Hospital
11	220	Timely filing limitation are not consistent with Medicaid.	*F*	Amerigroup, Peach State	Gwinnett Medical Center
11	314	CMO denied claims for untimely filing when provider held claims waiting for files to be updated by the CMO. CMO subsequently indicated they would waive the timely filing edit but that it was going to be a one-time exception.	*C*	Amerigroup	University Hospital
12	221	CMO's are failing to comply with contractual and regulatory requirements to pay emergency room (ER) claims in accordance with the federal "Prudent Layperson" standard.	*A,B, C-VHA*		
12	222	Denying ER facility charge against the ER professional charge as global and vice versa	*C - HH*	Peach State	Archbold
12	223	CMO not paying on ER claims for out of network providers	*C - HH*	Amerigroup	Memorial Hospital of Adele
12	224	ER payment received as triage when service merits that of an emergency	*C - HH*	Peach State, WellCare	Upson
12	225	CMO pays 86% of ER claims at triage rate then overturns 60% upon appeal	*C - HH*	WellCare	Fairview Park

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12	226	Inconsistent determinations of what constitutes an emergency at each appeal level.	*C - HH*	WellCare	Fairview Park
12	227	Not recognizing presenting diagnosis as emergent. Provider appeals 40% of PSHP triage payments and an undetermined percentage of WellCare triage payments.	*C - HH*	Peach State, WellCare	Archbold
12	228	Payment as triage when service merits that of an emergency	*C - HH*	WellCare	Liberty
12	229	CMO pays nearly all ER claims at non-emergent $XX rate. Provider has to appeal and submit medical records for reconsideration. Provider Manual mentions level 1, 2, 3 and 4 to aid in determination but has not provided listing in manual of what's included in each level.	*F*	Peach State	WellStar
12	230	CMO pays nearly all ER claims at non-emergent $XX rate. Provider has to appeal approx 90% of these claims.	*C - VHA*	WellCare, Peach State	Houston Healthcare
12	231	CMO pays 75% of ER claims at triage rate then overturns 40% upon appeal (provider appeals 100% of triage claims)	*C,D-CHOA*	WellCare	CHOA
12	232	Does not use prudent layperson standard in that consideration is not given to age of patient, time of visit or combinations of diagnoses billed, including the admitting diagnosis.	*C,D-CHOA*	WellCare	CHOA
12	233	CMO will not incorporate findings from appeals process in updating process for paying ER claims	*C,D-CHOA*	WellCare	CHOA
12	234	ER claims being paid at triage rate because CMO is not using prudent layperson standard. Appeal denied	*C-GHA*	WellCare	Liberty Regional Medical Ctr
12	235	Disagreement regarding determination of emergent-versus-nonemergent services in ER. Nonemergent is paid at all inclusive case rate and emergent is paid at percent of charges multiplied by facility-specific CCR.	*F*	WellCare	HCA Georgia (14 facilities)
12	236	ER claims being paid at triage rate. Appeal denied unresolved since March 2007	*C-GHA*	Peach State	Calhoun Memorial Hospital
12	237	ER claims not reimbursed according to contractual rate.	*C-GHA*	WellCare	Henry Medical Center
12	238	ER claims paid at triage rate when provider believes situation required emergent payment.	*E*	Peach State, WellCare, Amerigroup	Murray Medical Center
12	239	True emergency diagnoses claims are being paid under the triage rate. Provider states "we were instructed diagnosis that fall under this category for payments were published by DCH".	*F*	WellCare	Piedmont Healthcare
12	240	CMOs fail to pay emergency room claims in accordance with the federal layperson standard	*F*	WellCare	Memorial Health University Medical Center

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12	241	Vague interpretation of "prudent layperson's" determination of medical emergency resulting in $XX triage payments	*F*	WellCare	Oconee Regional Medical Center
12	242	ER claims paid at triage rate when provider believes situation required emergent payment.	*F*	WellCare, Peach State	Colquitt Regional Medical Center
12	243	ER claims paid at triage rate when provider believes situation required emergent payment.	*F*	WellCare	Atlanta Medical Center
12	244	Carriers are continuing to pay ER triage rates even though the diagnosis is on the list of true ER diagnoses.	*F*	WellCare	Northside Hospital
12	245	ER payment received as triage when service merits that of an emergency	*F*	WellCare	Phoebe Putney Memorial Hospital
12	246	ER claims paid at triage rate when provider believes situation required emergent payment.	*F*	WellCare	Floyd Medical Center
12	247	Failure to process ER claims according to the "prudent layperson" standard.	*F*	WellCare, Peach State	Sumter Regional Hospital
12	248	Observation admission that occurs with an ER visit only gets paid $XX triage rate.	*F*	Peach State	West Georgia Health System
12	249	ER claims being paid at $XX triage rate.	*F*	Peach State	Memorial Hospital and Manor Bainbridge
12	250	ER claims being paid $XX triage rate.	*F*	WellCare	Bacon County Hospital
13	251	Only 2 pediatric physician in Bainbridge and neither will accept WellCare patients, resulting in the enrollees seeking services in the ER or traveling to another town.	*F*	WellCare	Memorial Hospital and Manor Bainbridge
13	252	CMOs have not provided members of the subcommittee with data regarding the number of providers listed on their panels who are still accepting Medicaid patients	*B*		
14	253	CMO's systems and configuration inaccuracies often result in denial of payment or reduced payments to providers.	*A,B*		
14	254	All three CMO's have failed to comply with section 4.16.2.16 of the DCH - CMO contract, which requires the CMO's websites to be "functionally equivalent to the website maintained by the state's Medicaid fiscal agent."	*A,B*		
14	255	CMOs have not provided status of claims system problems that remain unresolved after 15 months.	*B*		

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14	256	There has been an increase in the number of claims that must be processed manually (using paper) instead of electronically because of CMO system functionality failures.	*B*		
14	257	POS 21 appears to contain an error resulting in CMO reporting paid amounts grossly higher than the billed amounts	*C - HH*	Peach State	Archbold
14	258	Timely billing from hospital claim does not show in system, must resubmit hard copy multiple times, then claim gets billed for untimely filing.	*C - HH*	Peach State	Upson
14	259	Centpatico claims on CMS-1500 showing tax id in field 24 rather than provider number.	*C - HH*	Peach State	Archbold
14	260	No access to Centpatico web portal	*C - HH*	Peach State	Archbold
14	261	835 file has pending claims attached - should be in separate file	*C - HH*	Peach State	Archbold
14	262	Incompatibility between Payformance being used with 835's by CMO and RelayHealth being used by provider	*C - HH*	WellCare	Archbold
14	263	Patient account number is not on the RHC Wrap Payment report and can't be reconciled to provider system	*C - HH*	Peach State	Archbold
14	264	Unable to check claim status, adjust claims, edit or resubmit online through web portal	*C - HH*	Peach State	Archbold
14	265	CMO loses claims keyed directly into their website and denies claims with no rejection notice	*C - HH*	Peach State	Flint River
14	266	The EOB's contain misleading or incorrect denial reason codes making it difficult to research and appeal the denial. Often then denied for timeliness.	*C - VHA*		
14	267	The EOB's contain misleading or incorrect denial reason codes making it difficult to research and appeal the denial. Often then denied for timeliness.	*F*	WellCare	WellStar
14	268	Individual line items on a claim may be processed on different claims, resulting in additional work for the provider to properly address any underpayment and account for it on their own books	*C - VHA*	WellCare	
14	269	CMO websites are not functionally equivalent as required by their contract with DCH.	*C - VHA*		
14	270	Web portal is not compatible with GHP and the data often does not match	*C - VHA*	WellCare, Peach State	Houston Healthcare
14	271	Authorizations cannot be viewed on the web portal	*C - VHA*	WellCare, Peach State	Houston Healthcare
14	272	CMO's do not consistently provide payer specific edits to electronic data interchange (EDI) vendors	*C,D-CHOA*		CHOA
14	273	Remittance advice shows same account number for different patient claims	*C,D-CHOA*	Peach State	CHOA
14	274	Remittance advice shows invalid/unrecognizable account number for different patients	*C,D-CHOA*	Peach State	CHOA
14	275	CMO loaded changes to hospital payment rates prior to contracted date	*C,D-CHOA*	Peach State	CHOA

Attachment A **Hospital Issues and Concerns Reported to Myers and Stauffer**

Source Key

A	*Memorandum from Department of Community Health to Board of Community Health dated 9/13/07*
B	*Provider Perspective Document regarding Joint Hearings on 8/28/07*
C	*Meetings with provider groups on 9/25/07*
D	*Individual meetings with select providers on 9/26/07*
E	*Copy of letter sent to Dr. Rhonda Medows on 9/20/07*
F	*E-mails, hard copy submissions by providers after 9/25 & 9/26/07 meetings*

All statements included in this document were provided by the hospitals responding and have not been fully confirmed.

Category	Item #	Concern Narrative as Expressed by Hospitals to Myers and Stauffer	Source	Specific CMO, if indicated	Provider
14	276	CMO sends hard copy correspondence in response to missing claims data in an electronic claim submission, rather than giving electronic feedback.	*C,D-CHOA*		CHOA
14	277	No HIPAA compliant denial codes on claim responses or a generic HIPAA code (A2), when claim is denied for other reasons	*C,D-CHOA*		CHOA
14	278	CMO's require hard copy claims on second submissions	*C,D-CHOA*		CHOA
14	279	CMO websites are not nearly as robust as that available through ACS, limiting ability to verify that all planned OP services have been fully authorized and inability to submit corrected 2nd claims electronically	*C,D-CHOA*		CHOA
14	280	Long time periods from date that CMO is made aware of provider loading or claim payment system configuration problems until the issue is corrected by CMO.	*C,D-CHOA*		CHOA
14	281	All contractual adjustments on remittance schedules must be manually calculated	*D-Tanner*	Peach State, WellCare, Amerigroup	Tanner Health System
14	282	Electronic claims are not showing up on the web portal even though provider is repeatedly rebilling. Eventually denied for timeliness	*E*	Amerigroup	Murray Medical Center
14	283	CMO's do not allow online corrections to claims, require paper claims	*F*	Peach State, WellCare, Amerigroup	Oconee Regional Medical Center
14	284	CMO websites are not functionally equivalent to ACS	*F*		Oconee Regional Medical Center
14	285	CMO websites are not functionally equivalent as required by their contract with DCH.	*F*	WellCare, Peach State	Colquitt Regional Medical Center
14	286	CMO websites are not functionally equivalent as required by their contract with DCH.	*F*	WellCare	Sumter Regional Hospital
14	287	Failure to correct system problems that produce erroneous denials or payments.	*F*	WellCare	Sumter Regional Hospital
14	288	CMO websites are not functionally equivalent as required by their contract with DCH.	*F*	Peach State	Phoebe Putney Memorial Hospital
14	289	Physician claims were denied due to system processing issues resulting in physician being forced to rebill and being charged for resubmissions. Cannot systematically change status on incorrectly denied claims	*F*	Peach State	Phoebe Putney Memorial Hospital
14	290	WellCare has begun making partial payments then recovering the original payment and repaying on all charges.	*F*	WellCare	Phoebe Putney Memorial Hospital

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Category	Item #	Concern Narrative as Expressed by Hospitals to Myers and Stauffer	Source	Specific CMO, if indicated	Provider
14	291	The EOB's contain misleading or incorrect denial reason codes making it difficult to research and appeal the denial. Often then denied for timeliness.	*F*	Amerigroup	Floyd Medical Center
14	292	Individual line items on a claim may be processed on different claims, resulting in additional work for the provider to properly address any underpayment and account for it on their own books	*F*	WellCare	Floyd Medical Center
14	293	CMO has a systems issue which results in professional fee claims being denied because of a mismatch on the TIN. Forces hospital to manually submit and track claim. Issue is ongoing.	*F*	WellCare	Gwinnett Medical Center
15	294	Payment offsets on Explanation of Payment with no account # reference	*C - HH*	Peach State	Archbold
15	295	CMO recoups payments when they downcode a DRG.	*C - VHA*	WellCare	
15	296	No rationale provided when CMO requests a refund of an audited claim	*C,D-CHOA*	WellCare	CHOA
15	297	CMO requests refunds which appear to be based on their assignment of the principal diagnosis solely on the physician's documentation in the discharge summary, instead of the documentation throughout the medical record from the time of admission until discharge.	*F*	WellCare	Memorial Health University Medical Center
15	298	CMO inappropriately recoups amount that was previously refunded by provider via check.	*F*	Peach State	Colquitt Regional Medical Center
15	299	CMO is requesting refunds on "sick" baby DRG accounts with a precertification. Disagreement regarding the determination of a "sick baby" DRG.	*F*	Amerigroup	WellStar
15	300	CMO does not provide detailed information regarding recoupments being made when it believes it has made payments to a provider in error.	*F*	Peach State	CHOA
15	301	CMO performing retrospective review resulting in denials not supported by written policy	*F*		Oconee Regional Medical Center
15	302	Claims are being paid correctly but then are recouped and paid at a lower level using the same DRG.	*F*	WellCare, Peach State	Northside Hospital
15	303	CMO recoups payments when they downcode a DRG.	*F*	WellCare	Phoebe Putney Memorial Hospital
15	304	CMO recoups payments when they downcode a DRG.	*F*	WellCare	Floyd Medical Center
16	305	CMOs are applying 72 hour rule to inappropriate situations. For example, 2 outpatient encounters within the 72 hours.	*C - VHA*		
16	306	72 hour rule is applied by CMO when patient goes to multiple facilities for the same service. First claim received is paid, all others denied for global fee.	*F*	Peach State	Piedmont Healthcare

Attachment A **Hospital Issues and Concerns Reported to Myers and Stauffer**

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All statements included in this document were provided by the hospitals responding and have not been fully confirmed.

Category	Item #	Concern Narrative as Expressed by Hospitals to Myers and Stauffer	Source	Specific CMO, if indicated	Provider
16	307	CMO inconsistently interprets their own rule that the 5th digit used in coding obstetrical patient services that are combined due to the 72 hour rule must be the same for all codes on the claim	*F*	WellCare	Memorial Health University Medical Center
16	308	CMOs are applying 72 hour rule to inappropriate situations. For example, 2 outpatient encounters within the 72 hours.	*F*		Colquitt Regional Medical Center
17	309	All physicians associated with FEIN are being report on RHC Wrap payment report resulting in the provider receiving wrap payments for physicians who should not be getting it	*C - HH*	Peach State	Archbold
17	310	Problem with RHC enrollment using same tax ID as hospital	*C - HH*	WellCare	Bacon
17	311	Provider has hospital based professionals and an RHC all under the same tax ID number as the hospital. CMO set up in their system is wrong and payments being issued to wrong name and effecting RHC payments.	*C-GHA*	WellCare	Bacon County Hospital
17	312	Claim denies because "incorrect billing form/provider". Provider states they are required to file on the 1500. Service is ambulance. Claim eventually denied for timeliness. Documentation also suggests issues with hospital being a participating provider and ambulance service being listed as a non-par provider.	*E*	Amerigroup	Murray Medical Center
17	313	Hospital contracts with outside physician to read EKG's and pays the physician a flat rate. The hospital then bills the CMO for both the technical and the professional component. The CMO pays the technical but denies the professional because it says the physician is "non-par"	*E*	WellCare, Amerigroup	Murray Medical Center

Provider Issues and Concerns Addressed by the Department of Community Health

1) As indicated on page 12 of the report, certain concerns and issues presented by Hospital providers to Myers and Stauffer were determined to be outside the scope of this engagement. These matters have been or will be addressed separately by the Department of Community Health. DCH's responses to each of the concerns and issues is indicated below.

2) The comments included under the heading "DCH Response" are those comments provided by the Department of Community Health, Division of Managed Care & Quality.

				Care Management Organization			
Category	**Concern Narrative as Expressed by Hospitals to Myers and Stauffer**	**Occurrence Count**	**Hospital Providers Commenting**	**Amerigroup**	**WellCare**	**Peach State**	**DCH Response**
14	*Claims processing system configuration and web portal issues*	41	14	4	10	18	DCH is investigating the issues and concerns brought by the providers and is working with the CMOs to develop solutions. DCH is also actively investigating any potential breaches of contract that may be occurring.
6	*Communication with CMO provider representatives and call center*	18	7	4	4	3	DCH is working with each CMO to address and develop effective solutions for the issues and concerns regarding difficulties with communications. Providers may contact the Provider Services area of the DCH Division of Managed Care & Quality if they have specific concerns about CMO communications that need to be addressed.
9	*Miscellaneous Processing and Confidentiality Issues*	4	1	0	1	3	Providers should immediately notify the CMO of any privacy-related matters. Provider concerns with CMOs related to privacy/confidentiality should be forwarded to DCH's Privacy officer. DCH is working to better educate providers regarding the process for reporting privacy issues including evaluating rapid response initiatives and dedicated provider access channel for reporting privacy violation concerns..
3.8	*Coordination between CMO and outside/carve out vendors*	3	2	0	3	2	Each CMO is responsible for oversight and compliance of their vendors and subcontractors. Providers should submit their issues and concerns with subcontractors directly to the Care Management Organizations. DCH is monitoring these situations. Providers may also contact the Provider Services area of the DCH Division of Managed Care & Quality.
3.4	*Claims payment issues resulting from patients that switch between managed care and fee-for-service*	2	1	0	1	0	According to the contract between DCH and each CMO, the CMO is responsible for paying for the services provided to its members. DCH works with the CMOs on an on-going basis to address member eligibility issues and errors in eligibility spans. Providers may contact the Provider Services area of the DCH Division of Managed Care & Quality if they have specific areas to be addressed.
13	*Access, provider retention and acceptance of Medicaid beneficiaries*	2	1	0	0	0	DCH is continuing to monitor geographic access to services and will continually address the issues with provider retention or access to services as they occur.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: WellCare
Hospital Provider: John D. Archbold Memorial Hospital (Archbold)

Date of Meeting: November 8, 2007
Time of Meeting: 12:30 PM – 1:30 PM

CMO Participants:

Michael Cotton, Chief Operating Officer

Hospital Participants:

Lynne Fritz, Vice President of Revenue Management

M&S Participants:

Ryan Farrell, Manager
Shelley Llamas, Manager
Holly Ross, Senior Analyst

Summary Description of Issue:

CMO is not recognizing the presenting diagnosis on a claim as emergent. 80% of WellCare triage payments are appealed with 60% being overturned upon appeal.

Discussions:

Ms. Fritz explained that the problem they are experiencing is that, when submitting emergency room (ER) claims to the CMO for payment, the CMO ignores the presenting diagnosis and only considers the final diagnosis when determining whether the provider should receive the full ER payment rate or the triage payment rate.

Mr. Cotton noted that in the past DCH used a list of diagnosis codes that were considered to be emergency diagnoses. WellCare attempted to use this as a standard when developing their ER coverage policies.

Ms. Fritz also noted that providers are required to submit the medical record with each ER claim they submit, thus they cannot appeal or

resubmit the claim for reconsideration electronically. She explained that this requirement slows down the process.

Mr. Cotton confirmed that providers do need to send in information for reconsideration. Under DCH fee-for-service policies, the rules were more liberal as it relates to the diagnoses considered emergencies. Mr. Cotton noted that WellCare does indeed look at the presenting diagnosis when considering claims submitted as ER claims. He also explained that in other states (e.g. Indiana and Illinois) hospitals are required to send in the medical record with their ER claims, just like WellCare requires in Georgia.

Mr. Cotton stated the system does not have anything in it to keep ER claims from paying as ER services.

Ms. Fritz noted that due to the lack of electronic 835s and the manual EOB processing, she cannot verify the exact percentage of the claims paid at the triage rate that are overturned and paid the full ER rate upon reconsideration. She indicated that the rate is much higher than was experienced with traditional Medicaid prior to the CMO conversion. She will send information to M&S correcting the provider's earlier claim that 60% are overturned upon reconsideration. (Mr. Cotton noted that these situations are not considered appeals since the claim was not denied. They are "reconsiderations.)

Ms. Fritz noted that Archbold does not have an automatic tracking system for these cases. She stated that the ER [service claim] rejection was 10-15% a year ago. She noted that field 76 on the UB-92 is the admitting diagnosis, while field 67 is the final diagnosis. She restated her belief that WellCare's system is only looking at the final diagnosis in the system's algorithm and thinks the presenting diagnosis should also be considered.

Ms. Fritz continued by stating that EMTALA (Emergency Medical Treatment and Active Labor Act) stipulates that if a hospital does not treat the patient when they come into ER, the hospital would be violating federal law.

Ms. Fritz asked if WellCare could relax their standards and pointed out that the cost WellCare spends looking at each case could be reduced by changing these policies.

Mr. Cotton again stated that WellCare does look at the admitting diagnosis.

Ms. Fritz rebutted, “You look at it after the fact.”

Mr. Cotton noted that WellCare does look at the admitting diagnosis during the initial claim processing. He pointed to ForeThought Group’s report for DCH that examined this issue and confirmed that WellCare does indeed utilize the admit diagnosis in their processing. Mr. Cotton continued by noting that ER utilization is important to WellCare. He indicated that between June 2006 and June 2007, of the ER claims, 63% were paid at the triage rate on the initial review and 37% were paid at the ER rate. After additional review (reconsideration), 42% are reimbursed at the ER rate and 58% at the triage rate. He noted there is a two-tier review that includes both ER doctors and nurses. Mr. Cotton explained that WellCare does look at field 76 and “now” looks at the time of day. He indicated that WellCare does recognize that some markets are rural and that no after hour clinics exist in those markets, so they give these hospitals a case rate. He indicated that WellCare would be willing to discuss this option with Archbold, too. Ms. Fritz asked Mr. Cotton to forward a copy of the ForeThought Group’s report for DCH for her review along with reports from the WellCare system indicating Archbold’s 5 system hospitals’ ER triage payment % and the full ER payment %.

Ms. Fritz indicated that her hospital does not have a provider representative at this time. Mr. Cotton mentioned Earl, to which Ms. Fritz responded that Earl has not been responsive and has only been to the hospital twice. She noted they have been working with Sally Bradley.

Mr. Cotton indicated that he would work with Matt to ensure Archbold has a provider representative.

Ms. Fritz noted they do not have contract compliance software, so they have to perform all their analyses manually.

Mr. Cotton asked if Archbold would be open to a different fee schedule/case rate.

Ms. Fritz noted she was not opposed, but wants things to run cleanly.

Mr. Cotton noted that there are providers being loaded that Archbold does not want loaded.

Ms. Fritz stated that these are mostly doctors who have indicated they are not going to participate.

Mr. Cotton indicated that he would send data on Archbold's triage and ER claim payments to her.

Ms. Fritz asked Mr. Cotton, "As a company and as the Georgia product sits today, are you comfortable with what you are doing with ER determinations?"

Mr. Cotton responded, "Audit compliance says we are doing it the right way."

Ms. Fritz noted there are nurses on the ground, but not much happening to educate people to not go to the ER [for primary care purposes]. Ms. Fritz continued, "We don't want them in the ER, but if they show up, we have to treat them. We are implementing medical screen out policies where patients will be turned away. We thought the CMOs were going to be more active in outreach."

Mr. Cotton replied, "We are. CHOA/Grady gives us lists of [potential misuse] of ER. We do that with a number of hospitals by going to the patient's home to provide outreach. Let us figure out how we can do this for Archbold."

Ms. Fritz noted, "Rural hospitals across the state are having trouble making payroll while CMOs are in the news about their profit margins going up."

Mr. Cotton responded, "WellCare is a public company. We can work with you differently by changing policies to help Archbold."

Ms. Fritz replied, "This (issue) is not specific to Archbold. It's statewide. We do not feel like the mission and the intent are aligned."

Mr. Cotton responded, "No one advertises when we give money to programs that help the community. If there is something we can do, let us look at it. We have found abuses such as [we found] in billing."

Ms. Fritz explained that the initial contracting phase with WellCare, which was three months after implementation of managed care in Georgia, mitigated their losses. Rural areas may have 2 physician offices that are not open after hours, thus the ER is utilized more frequently. Archbold knew that this circumstance and the $50 triage rate was going to be a hit [financially since they would receive the full ER payment less often than they did under FFS]. They knew it was going to be $50 on non-emergent,

so they asked WellCare during the contracting phase for a $XX non-emergent rate and received $XX. Ms. Fritz noted some of the ER visits may only be $X-$X, but now those are being paid at the triage rate of $50 (for most hospitals). If a service is (deemed to be an) emergency, then Archbold is paid at the contracted ER amount. If the service is deemed non-emergent, then some providers are paid $XX.

Ryan asked how much of Archbold's business is made up of Medicaid. Ms. Fritz replied that about 15-18% of John D's business is Medicaid and noted it is higher for rural hospitals. She continued by noting that WellCare is one of the smaller CMOs they deal with. Per Ms. Fritz, the CMO is technically compliant with their contract with DCH because at some point in the process they are looking at the presenting diagnosis, but making the provider go through appeal process and print the document on a much higher number of cases. Ms. Fritz indicated this impacts the business office substantially. Ms. Fritz noted that a clean bill (claim) costs approximately $48 to submit (for Archbold) and going through the ER appeals process, requiring submission of the paper chart, greatly increases that cost. She also indicated that it is to the advantage of both the CMO and provider to keep as much of the process electronic as possible, thereby reducing handling costs.

Ms. Fritz noted that operations run much smoother when dealing with WellCare (as opposed to other CMOs), with the exception of the provider issue. She continued by noting before, when using ACS, everything was electronically submitted or corrected on the Georgia Health Partnership (GHP) portal, and now with the CMOs, hospitals have to go back to paper submissions and claim corrections.

Mr. Cotton asked if Ms. Fritz was aware that prior authorizations and resubmissions could be done on-line now. Ms. Fritz was unaware.

Ryan Farrell thanked everyone for coming and asked that he be copied on the correspondence when resolving the issues discussed in today's meeting. The meeting was subsequently ended.

Status: Unresolved. Mr. Cotton indicated he would be setting up a meeting with Archbold in Thomasville in the coming weeks to discuss their issues.

Ms. Fritz indicated on December 11, 2007 that, "According to our staff, we cannot access claims online to make corrections or resubmissions, as Mr. Cotton has stated." Ms. Fritz also indicated the following on December 11, "Please note that I have not heard from Mr. Cotton at all since the meeting, nor has he followed up with the info he was going to send me: 1. The ForeThought group report for DCH he referenced; 2.

Report from the WellCare system on the ER payment % and ER Triage % for our 5 hospitals."

Mr. Cotton also stated in an e-mail on December 6, 2007, that Archbold had agreed to allow WellCare to load their [Archbold's] primary care doctors into WellCare's network. Lynn Fritz confirmed on December 17, 2007 that Archbold had agreed with WellCare on December 5, 2007 to load these providers as "participating, but closed to new patients." However, Lynn also stated "… right after that meeting, I discovered that WellCare has changed our CCR for payment of outpatient services, in their system, and are therefore not paying us correctly. I notified Beth Nunnally to hold off on the addition of our primary care doctors to their network until we can straighten this out. She acknowledged receipt of that message but I have not heard back from them on this since last week."

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on the notes.

CMO: Peach State
Hospital Provider: Phoebe Putney Memorial Hospital

Date of meeting: November 8, 2007
Time of meeting: 10:00 PM – 11:30 PM

CMO Participants:

Mike Cadger, President and CEO
Sara L. Neale, Director, Ethics and Compliance

Hospital Participants:

Gail Carter, Vice President Revenue Cycle
Pat Sumner, RN, Executive Director Managed Care

M&S Participants:

Ryan Farrell, Manager
Shelley Llamas, Manager

Summary Description of Issue:

Provider's claims are not being paid according to the agreement with the CMO. Examples:

#18 Peach State denies revenue code 260 (IV Therapy). They are now requiring CPT/HCPC codes to break down each item under revenue code 260. No other payer requires CPT code for revenue code 260 not even WellCare or traditional Medicaid. The provider asks that the CMO cease this practice that adds an extra burden on providers.

#20 Peach State had system processing problems that caused denials of a physician's claims. The physician was asked to resubmit the claims although he would be charged for the resubmissions. The provider believes that Peach State should have a process to change the status on denied claims without

having to resubmit the claims. At the least, the provider believes there should be no charge for the resubmission.

Discussions:

Ryan Farrell explained that the purpose of the meeting was to discuss only the issue presented to the participants.

After the issues being discussed were clarified, Ms. Neale explained that since she did not receive the documentation from Phoebe Putney until after 3:30 PM the previous day and was in meetings all day, there was no time for her to have her staff research the issues prior to this meeting. She noted she would discuss the documentation and the issues with her staff on Friday.

Ms. Sumner indicated the second issue has apparently been resolved (in the system), but the problem continues to occur over and over, then the next month they (Phoebe Putney) experience more problems. She continued that the one example may have been resolved, but there are more issues that need to be resolved.

Ms. Sumner continued that the revenue code issue (Revenue Code 260 IV Therapy) is a system problem because Phoebe Putney believes the system is recognizing the revenue code only as home care infusion instead of hospital infusion.

Ms. Carter indicated she had brought this up with the provider rep.

Ms. Neale noted it is their intent to look at the broad picture and not solve the individual claim. Mr. Cadger confirmed that Peach State would look further than just the example claim. Mr. Cadger noted processes have improved.

Ms. Neale went on to explain the Peach State's AmiTest system to Ms. Carter and Ms. Sumner. She noted the test system is set up with all claims containing the specified code and checks to see if there are problems with payment. They will then drill down to determine the root cause of the error in payment.

Mr. Cadger stressed that it is important to Peach State that the claims are paid accurately and timely.

Ms. Carter noted that she feels only specific issues are fixed but the errors keep occurring.

Mr. Cadger noted that Peach State is restructuring so that the provider representative owns the problem and they see that it gets fixed. They will work with network contracting (Yolanda) and provider education. They are also going to be setting up a dedicated line for providers to call.

Ryan Farrell thanked everyone for coming and asked that he be copied on the correspondence when resolving the issues discussed in today's meeting. The meeting was subsequently ended.

*It should be noted that several topics not related to the two issues listed, above, were discussed. Since these topics and issues were not related to the issues and topics on the agenda, they are not included above. We have summarized these issues in the 'Other Items' section, below.

Status: Unresolved. Ms. Neale noted during the meeting that because she did not receive the documentation in time to research, she would present the documentation to her staff on Friday (Nov. 9). Mr. Cadger indicated that he would be meeting with Phoebe representatives in the coming weeks to discuss their contracting issues.

On December 6, 2007, Ms. Neale indicated the following, "It is the intention of PSHP to meet and discuss all the interview[s] held last month and do a recap of actions taken since these meetings. That meeting is scheduled for Dec 20th and I hope to send our conclusions to you by the end of December. We are continuing to actively work to resolve these issues identified."

Other Items:

Please note that during the November 8 meeting, since Peach State did not receive Phoebe Putney's information related to the two issues in time to research for the meeting, the following discussions (not related to the two issues) occurred.

Ms. Sumner presented examples of providers who were enrolled in January but have yet to receive their provider numbers and are, therefore, paid at the out-of-network rate. She also pointed out their efforts to open a midwifery clinic to assist in patient access for OB patients and requested that those providers' enrollment be rushed as they are received.

Ms. Sumner and Ms. Carter also discussed Phoebe's other efforts for patient access. Phoebe has a Medicaid Recovery consultant visiting physician offices in order to enroll self-pay patients in Medicaid as early

in the pregnancy as possible.

Ms. Carter offered to send a report listing emergency room "frequent fliers" for Peach State to review. Ms. Carter was given the name of Kevin Bonner to send the report for follow up.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: Peach State
Hospital Provider: Henry Medical Center

Date of Meeting: November 7, 2007
Time of Meeting: 2:00 PM – 4:00 PM

CMO Participants:

Mike Cadger, President and CEO
Sara L. Neale, Director, Ethics and Compliance

Hospital Participants:

Althoria Warren, Blankenship & Associates
David Blankenship, Blankenship & Associates

M&S Participants:

Ryan Farrell, Manager
Shelley Llamas, Manager

Summary Description of Issues:

- Issue #1: Normal and C-Section deliveries are paid at DRG rate and not the contracted rate.
- Issue #2: Stop Loss claims are not being paid according to the first dollar provision.
- Issue #3: Outpatient - all other claims are not paid according to Henry Medical Center's CCR (cost-to-charge ratio).
- Issue #4: ER (emergency room) claims not paid according to rates specified in HMC contract. HMC has 5 levels of payment ER level 1 through 5. HMC is being paid the triage rate for levels 1 and 2 in several cases.
- Issue #5: Observation claims not paid according to HMC's contracted rate.
- Issue #6: MRI/CT scans are being paid at a percent of charges instead of contracted case rate.
- Issue #7: False Labor not paid according to contracted rate.

- Issue #8: ASC groupers and non-groupables not paid according to contracted rate.

Discussions:

Ryan Farrell explained that the purpose of the meeting was to discuss only the issue presented to the participants. Mr. Farrell then turned it over to the provider to present their supporting documentation for the issues.

Ms. Warren began to explain an issue relating to Medical, Surgical and CCU/PCU per-diems not being paid according to the contracted rate. Mr. Farrell interjected that this issue was not on the table for discussion since it was not on the list provided to the CMO but items 2-9 on HMC's list were open for discussion today.

Issue #1: Normal and C-Section deliveries are paid at DRG rate and not the contracted rate.

Ms. Warren continued her presentation addressing the second issue on HMC's list. According to Ms. Warren, "Normal and C-Section deliveries are paid at a DRG rate and not the contracted rate." Ms. Warren noted that HMC receives $XXX for a delivery but they are not being paid $XXX.

Ms. Neale noted that Peach State has made a correction to the system and has identified the claims relating to the error. The claims have not passed the processing stage. As of Friday (Nov. 2), testing was still in progress to reprocess the claims. Peach State will re-run the claims and match against what was paid. The report will tell them (Peach State) what is owed to the provider or if an overpayment was made. Ms. Neale indicated that no resubmission by the provider will be needed. Ms. Neale did not have a date as to when the reprocessing would occur, but would notify HMC when Peach State knew the date the reprocessing was to occur. She noted that all she knew was that the claims were in the process of being reprocessed.

Ms. Warren noted Steve Pace had been helping HMC resolve some of their claim issues. During this discussion it was identified that HMC did not currently have a provider representative and is not part of regular Joint Operating meetings. Ms. Neale asked Ms. Warren if HMC would like to be part of the Joint Operating meetings to which Ms. Warren responded "yes". Ms. Neale asked if anyone else is working with them on claims issues. Ms Warren replied "no". Ms. Neale indicated that Peach State would work with HMC to provide a better set up.

Issue #2: Stop Loss claims are not being paid according to the first dollar provision.

In regards to Issue #2, Ms. Neale responded that the system setup is correct. The claim pays manually and in the claim example provided, it was incorrectly paid and underpaid. Ms. Neale asked if this was the only claim or if there were more with similar characteristics.

Ms. Warren noted there are more and they have not sent the other claim examples. Ms. Neale asked Ms. Warren to submit the other claims to her electronically, providing the claim number so they (Peach State) can investigate. Ms. Neale asked if Ms. Warren knew the volume of claims that were involved. Ms. Warren concurred that there were more claims and briefly went through some of the reports brought to the meeting and indicated that HMC would send the claim examples to Peach State.

Issue #3: Outpatient - all other claims are not paid according to Henry Medical Center's CCR (cost-to-charge ratio).

Ms. Neale noted that a system correction occurred in October 2007 and a Claims Project is in the process of being created. Ms. Neale continued noting that the (system) fix is completed (to correct this issue), but she needs to give HMC the date this fix occurred. Ms. Neale confirmed that claims will be adjusted automatically and that she will send an e-mail to HMC with that information by Friday. She noted that she could not provide a tentative date of completion until the Claims Project is created.

Issue #4: ER (emergency room) claims not paid according to rates specified in HMC contract. HMC has 5 levels of payment ER level 1 through 5. HMC is being paid the triage rate for levels 1 and 2 in several cases.

Ms. Neale confirmed that this issue requires a system fix. It is currently using the "lesser of" logic. Ms. Neale indicated that she would need to request a system fix. She noted that after the fix, Peach State will need to set up a Claims Project, and then she could provide a timeframe for completion to HMC. Ms. Neale indicated that she did not know if this issue has been previously identified. She noted that she will have a better idea on Friday and it will be a week or so before she can provide any dates.

Ms. Neale noted that the provider is not using the "lesser of billed charges or allowed amount" in their claims review logic, but the CMO does use this "lesser of" logic.

Mr. Cadger noted that Medicaid retroactively accounts for “lesser of” logic through the use of settlements through cost reports. However, CMOs only method for payment is on a claim-by-claim basis, and therefore they use the lesser of billed charges or the fee schedule amount.

Mr. Blankenship indicated that they (the hospital) should not have agreed to put the “lesser of” logic in their contract. Mr. Blankenship continued that they believed that reimbursement was not going to be less than Medicaid (fee-for-service).

Mr. Cadger noted that a standard contract exists for CMOs to use with providers but the standard contract did not contain specific rules for claims adjudication that might eliminate some ambiguity. He noted that DCH should have a standard contract that includes the rules for adjudication.

Ms. Neale noted HMC’s contract is different than other provider contracts.

Ms. Warren noted that HMC was unaware that there was customization of contracts. Ms. Warren noted they may not have reached the right people to get their claims issues resolved.

Issue #5: Observation claims not paid according to HMC’s contracted rate.

Ms. Neale indicated that Peach State is showing six claims reduced to billed charges instead of the case rate (“lesser than” case rate).

Ms. Warren indicated that her data reveals that more claims are affected by this issue.

Ms. Neale asked if these issues have been submitted to Peach State previously. Ms. Warren responded that these claims were sent back through as claim resubmissions and HMC was told that the claims paid correctly.

Ms. Neale asked Ms. Warren to send her the additional claims.

Mr. Blankenship agreed that this is a contracting issue and that the claims paid in accordance with their current contract. Mr. Blankenship stated that HMC disagrees with the way the contract was set up. Mr.

Blankenship noted HMC should not have signed the contract and will not negotiate the contract this way in the future.

Mr. Blankenship noted that HMC will look at the claims to be sure, but was guessing that there was no payment issue because of the way the contract was set up.

Mr. Cadger also noted that this is a contract issue and there is no clear policy from DCH on how CMOs should pay these claims.

Ms. Warren agreed there does not appear to be an issue [with these claims not paying according to contract terms].

Ms. Neale noted that she needs the specific claim examples and Ms. Warren agreed to send the claims to Ms. Neale.

Issue #6: MRI/CT scans are being paid at a percent of charges instead of contracted case rate.

Per Ms. Neale, the outpatient location code is paying at the case rate, while the emergency room location code is paying at the fee schedule rate. On the claims reviewed, there should not have been any reimbursement since MRI and CT are included in the emergency room reimbursement rate. Ms. Neale noted that she needed specific claim examples.

Ms. Warren indicated that she would send the claim examples to Ms. Neale. Ms. Neale inquired about the volume of claims HMC has that show a location of outpatient. Ms. Warren responded that, at a quick glance it appears that there are 25 claims resulting in $XXX in additional reimbursement. Ms. Neale confirmed that Ms. Warren would send her the 25 claims. Ms. Neale then indicated that this would be a contract issue.

Ms. Warren pointed to the reimbursement hierarchy on page 9 of their contract. On the hierarchy, if the service is in an emergency room, MRI/CT is included in the emergency room reimbursement. Mr. Blankenship noted that HMC should probably discharge the member into an observation room before performing an MRI to get around this. HMC confirmed that this issue was a contract issue. Ms. Warren confirmed that HMC would look at the detail of these claims before submitting to Peach State.

Issue #7: False Labor not paid according to contracted rate.

All parties agreed that this issue applies to the contract's "lesser of" logic. Ms. Warren noted that her report does not indicate whether the claim payment is using the "lesser of" logic (billed verses allowed amounts). She noted that the 45-50 claim examples would add $XXX-$XXX in additional reimbursement.

Ms. Neale asked Ms. Warren to send her the claim examples if these claims are not being paid using the "lesser of" logic.

Issue #8: ASC groupers and non-groupables not paid according to contracted rate.

Ms. Neale noted that she does not yet have an answer for this issue. Per Ms. Warren, this is not a "lesser of" logic issue. Ms. Warren noted that for at least 25 claims they show $XXX is outstanding from Peach State. Per page 4 of the contract [between HMC and Peach State], there are different contract rates by ASC group. Ms. Neal asked Ms. Warren to send her the claim examples if they are not associated with the "lesser of" logic issue.

Ms. Neale recapped the meeting by noting that Peach State needed to provide HMC with someone from the public relations area and the claims liaison area. She also noted Peach State needs to establish Joint Operating meetings with HMC. Ms. Neal noted that they could move claim issues up the priority list and can meet once a week if needed.

Ms. Neale indicated that she is in the compliance area and she will make sure these issues are resolved. Ms. Neale noted that by Friday (Nov. 9, 2007) she would let HMC know who their provider rep and claims liaison will be.

Ryan thanked everyone for coming and asked that he be copied on the correspondence when resolving the issues discussed in today's meeting. The meeting was subsequently ended.

Status:

Issue #1: Unresolved. System correction has been made and claims to be reprocessed are still in testing per Ms. Neale.

Issue #2: Unresolved. Ms. Neale noted that this was a manual calculation issue/error and not a system error. Ms. Warren is to send more claim examples to Ms. Neale.

Issue #3: Unresolved. Ms. Neale noted that the system was corrected last month and a claims project to reprocess the claims is in the process of being established. Ms. Neale will provide a tentative date of completion, if possible, by Friday; however, she cannot give provide an expected date of completion until the Claims Project has been completely set up.

Issue #4: Unresolved. Ms. Neale indicated after system fix is completed, Peach State will automatically reprocess the affected claims. Ms. Neale will provide a timeline estimate to HMC by Friday.

Issue #5: Contract issue – Issue is not covered under the scope of the M&S workplan.

Issue #6: Potentially a contract issue – M&S needs HMC and Peach State follow-up to determine whether issue should be included in M&S workplan.

Issue #7: Unresolved. Ms. Warren is to send claim examples to Ms. Neale for further review.

Issue #8: Unresolved. Ms. Warren is to send claim examples to Ms. Neale for further review.

On December 6, 2007, Ms. Neale indicated the following, “It is the intention of PSHP to meet and discuss all the interview[s] held last month and do a recap of actions taken since these meetings. That meeting is scheduled for Dec 20th and I hope to send our conclusions to you by the end of December. We are continuing to actively work to resolve these issues identified.”

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: Peach State
Hospital Provider: Fairview Park Hospital

Date of Meeting: November 7, 2007
Time of Meeting: 4:00 PM – 5:00 PM

CMO Participants:

Mike Cadger, President and CEO
Sara L. Neale, Director, Ethics and Compliance

Hospital Participants:

Vi Crain, Interim Director of Payment Resolutions

M&S Participants:

Ryan Farrell, Manager
Shelley Llamas, Manager

Summary Description of Issue:

CMO pays a Medicaid short stay rate instead of a DRG rate as specified in the contract between the provider and CMO.

Discussions:

Ryan Farrell explained that the purpose of the meeting was to discuss only the issue presented to the participants. Mr. Farrell then turned it over to the provider to present their supporting documentation for the issue.

Ms. Crain explained that the CMO's policy on short stay was not clear in the contract and thus they were not being paid correctly.

Ms. Neale pointed to page 21 of 38 of the contract, specifically to Exhibit A, #3. Inpatient Outliers. This section states "Outlier payments shall be made in accordance with the State outlier payment methodology."

Ms. Neale then pointed to Georgia's Hospital Services provider manual, Appendix C, section 2.2 and 2.3.

Ms. Crain indicated that the policy was not clear.

Mr. Cadger responded that Peach State could make it clearer in their (Fairview's) contract if the provider wished to amend the contract. He indicated that Peach State had amended other provider contracts as a result of the provider and CMO not agreeing on this issue.

Ms. Crain indicated that she would return to her facility and discuss this option with others at Fairview.

Mr. Farrell thanked everyone for participating and asked that he be copied on the correspondence when resolving the issue discussed in today's meeting. The meeting was subsequently ended.

Status: Unresolved. As of the end of the meeting, the issue remains unresolved. The provider contends that their contract was not clear as to how short-stay claims are to be paid. Peach State indicated contract could be re-written/amended so that this would be clearer to the provider. The issue is pending Fairview's internal review of this option.

On December 6, 2007, Ms. Neale indicated the following, "It is the intention of PSHP to meet and discuss all the interview[s] held last month and do a recap of actions taken since these meetings. That meeting is scheduled for Dec 20th and I hope to send our conclusions to you by the end of December. We are continuing to actively work to resolve these issues identified."

On December 7, 2007, Ms. Crain stated the following in an e-mail to M&S, "[T]he Medicaid manual segregates out the calculation methodology of an outlier and CCR Reimbursement, and since only the outlier reimbursement methodology was addressed in the contract, HCA will not honor the CCR reimbursement on 'Short Stay' claims."

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: Peach State
Hospital Provider: Atlanta Medical Center

Date of Meeting: November 7, 2007
Time of Meeting: 1:00 PM – 2:00 PM

CMO Participants:

Mike Cadger, President and CEO
Sara L. Neale, Director, Ethics and Compliance

Hospital Participants:

Helen Young

M&S Participants:

Ryan Farrell, Manager
Shelley Llamas, Manager

Summary Description of Issue:

CMO is not paying for metabolic screening add-on for newborns. CMO denies appeal and states claims paid appropriately.

Discussions:

Ryan Farrell explained that the purpose of the meeting was to discuss only the issue presented to the participants. Mr. Farrell then turned it over to the provider to present their supporting documentation for the issue.

Ms. Young explained that the issue does not appear to remain an issue after September 29, but for claims prior to September 29, the issue remains unresolved.

Ms. Neale noted that her notes concur with the provider's concern. She further explained that a system change was made on September 13 (2007) and a "claims project" has been initiated that will bump against all previous claims to identify any over and underpayments. They will be looking at all claims from September 30, 2006 forward. She noted that

they are in the process of this “claims project” and will be determining the number of claims that need adjusted. Ms. Neale noted this was a set-up issue and some claims went through (paid) while others did not and this had to be corrected. She continued that when the claim paid, at that time, it paid correctly (according to the system set-up).

Ms. Young asked when the claims project would be completed to which Ms. Neale replied that the project was currently running and she would need to send her (Ms. Young) a timeframe of when it will be completed. Ms. Neale noted she would attempt to send this timeframe information to her (Ms. Young) by Friday (Nov. 9, 2007).

Ms. Young asked why this not was previously considered an “issue” by Peach State if 300 claims are in appeal. Ms. Neale noted that if the claims come in piecemeal, as opposed to a bulk project, no one might have noticed a problem existed. Ms. Neale noted that she did not know when this issue was submitted, but only knew that it is being corrected.

Ms. Neale noted that in the “claims project”, the timeliness system edit is waived (i.e turned off).

Mr. Cadger stressed that Peach State wants to pay all claims accurately and in a timely manner.

Ms. Young noted she does not believe this has been a malicious attempt on the part of the CMO to not pay claims, but it would be good to know to whom to escalate issues so that they can be kept from “snowballing” (i.e. compounding).

Mr. Cadger noted that Joint Operating Committees meet as needed, such as once a week, once every two weeks, or once a month. These meetings are one-on-one between key contacts from the provider and the provider representative/CMO.

Ms. Young noted that routing issues to the right person (within Peach State) so they can be addressed would be helpful. Ms. Young continued that the experiences between the hospital and the CMO have not always been a bad experience (i.e. negative).

Ms. Neale provided her email address and her phone number to Ms. Young in case she had any questions/additional issues.

Mr. Farrell thanked everyone for participating in the meeting and the meeting was concluded.

Status: Unresolved. As of the end of the meeting, the issue remains unresolved. According to the CMO, and verified by the provider, the system correction was made. However, the reprocessing of previous claims through the "claims project" has not yet occurred. Ms. Neale noted that she would provide to Ms. Young a timeframe as to when she should expect the claims to be reprocessed. Ms. Neale hoped to be able to provide the information on Friday, November 9, 2007. Myers and Stauffer asked to be copied on all relevant correspondence between the two parties.

On December 6, 2007, Ms. Neale indicated the following, "It is the intention of PSHP to meet and discuss all the interview[s] held last month and do a recap of actions taken since these meetings. That meeting is scheduled for Dec 20th and I hope to send our conclusions to you by the end of December. We are continuing to actively work to resolve these issues identified."

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: Amerigroup
Hospital Provider: Children's Healthcare of Atlanta (CHOA)

Date: November 7, 2007
Time: 12:00 p.m. – 2:00 p.m.

CMO Participants:
Tisch Scott, COO
Craig Bass, President and CEO

Hospital Participants:
Wes Adams, Director, Patient Financial Services
George Dilworth, Director, Finance Managed Care

M&S Participants:
Beverly Dilley, Manager
Terri McLean, Sr. Health Care Policy/Reimbursement Analyst

Issue #1: CMO requires CPT identifiers on all outpatient claims for a broad list of revenue codes despite a smaller contracted list.

Discussions: Beverly Dilley read the description of the issue and asked Mr. Adams to explain the issue. Mr. Adams indicated that the claims were being rejected because they were missing a CPT procedure code with the revenue. Mr. Adams indicated the issue has been resolved and the claims have been corrected. Ms. Scott confirmed that there were some initial set up issues and the edits have been corrected. Ms. Scott indicated interest is automatically paid on all adjustments unless the adjustment due was made for the provider on an exception basis (i.e. waive timely filing limit).

Mr. Dilworth expressed concern with conflicts between the provider manual and the actual requirements with regards to this issue as well as with procedures requiring authorization. Mr. Dilworth indicated that they were told the authorizations included procedure group families rather than specific procedure codes but claims are denying unless there is an exact match on procedure code.

Ms. Scott confirmed that Amerigroup's Medical Management personnel had erroneously communicated that family code sets were used and confirmed that there must be an exact procedure code match. Ms. Scott indicated that Amerigroup has developed and implemented a web-based program to look up procedure codes for authorization requirements. CHOA tested the application and provided many helpful suggestions. Ms. Scott indicated procedure code authorization requirements vary depending upon where the service is performed. Mr. Adams indicated that the procedure code sometimes changes during the surgery or when the test is performed. Amerigroup requires the provider to submit the claim, wait for the denial and appeal the claim or request a retrospective review to modify the authorization and then resubmit the claim. Mr. Adams indicated that the other CMOs allow modification of an authorization within twenty-four hours. Mr. Adams asked Amerigroup if CHOA could hold the claim and appeal and submit a retrospective review request to modify the authorization prior to denial. Ms. Scott indicated she would follow up with an answer

Issue Status: Resolved. The original issue was resolved through contract revisions. Ms. Scott will follow up with CHOA and copy her response to Myers and Stauffer regarding the authorization retrospective reviews. Ms Scott stated via e-mail, "Amerigroup has bi-weekly meetings with CHOA and this was discussed in our meeting on December 4, 2007. We also have a follow-up meeting with CHOA leadership on January 7, 2008 with Amerigroup's leadership from their corporate office to discuss authorization changes for 2008. This will be an on-going implementation through out 2008."

Issue #2: Timeliness, including using admission date to start timeliness determination and short span of time allowed.

Discussions: Ms. Dilley read the description of the issue and asked Mr. Adams to explain the issue. Mr. Adams indicated that Amerigroup is using the admission date rather than the discharge date when determining timeliness of filing. This creates problems for CHOA when the inpatient stay is lengthy. Ms. Scott confirmed that Amerigroup's system is unable to calculate the filing time based on the discharge date and does calculate it based on the admit date. Amerigroup is unable to resolve this issue systematically but has [agreed to manually process these type of claims] to calculate from the discharge date.

Mr. Adams inquired about a specific claim that has been outstanding for several months. Ms. Scott advised Mr. Adams that the claim was submitted with incorrect days and will continue to deny until the dates are corrected. The patient was effective with [another hospital provider] for a portion of the admission and CHOA needs to resubmit the claim to Amerigroup for only the dates that the member was effective with Amerigroup. Ms. Scott stated via e-mail, "Received revised claim from CHOA and it was processed on 12/5/07."

Status: Resolved.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: Amerigroup
Hospital Provider: Floyd Medical Center

Date: November 8, 2007
Time: 10:00 a.m. to 11:00 a.m.

CMO Participants:

Leigh Davison, AVP, Health Plan Operations, Georgia
Tisch Scott, COO

Hospital Participant:

Teresa Prevost, Director of Revenue Management

M&S Participants:

Beverly Dilley, Manager
Terri McLean, Sr. Health Policy/Reimbursement Analyst

Description of Issue: CMO is using bundling and coding techniques contrary to those utilized by MCS and commercial payors.

Discussions: Beverly Dilley read the description of the issue and asked Ms. Prevost to explain the issue. Ms. Prevost indicated that Amerigroup is using a software program that bundles and unbundles revenue and procedure codes and is also bundling and paying various surgery and ER claims in a manner inconsistent with Floyd's expectations. Ms. Scott confirmed Amerigroup uses Claim Check software and provided a copy of a provider bulletin regarding the software.

Ms. Prevost indicated Floyd is non-participating with Amerigroup and is reimbursed at xx% below Medicaid and questioned why Amerigroup was not paying according to DCH payment policies. Ms. Scott explained that Amerigroup's contract with DCH does not indicate that it must pay claims in accordance to DCH payment policies.

Ms. Prevost stated that if a patient arrives in the ER and is later transferred to an observation bed, Amerigroup only pays the observation charge, contrary to how Medicaid or other payors pay. Ms. Scott indicated that Amerigroup pays the highest level of care. Ms. Prevost indicated that CMS rules indicate to bill the charges separately and other payors allow all charges. Ms. Scott indicated that they are not systematically able or willing to contract with providers to pay outside of the standard claim processing rules related to paying providers at the highest level of care. Both parties agreed that this was a contracting issue and they would continue the conversation outside of the meeting.

Another issue Floyd presented is that surgeries are filed with a 360 revenue code (for OR services) and the OR services are billed in time units, i.e., the first hour is one unit, and each subsequent 30 minutes is an additional unit. All units are reported on the claim and Amerigroup has been dividing the OR charge by the number of units and paying for one "unit." Floyd indicates they bill all payors the same way and have never experienced underpayments related to this. Floyd has presented this issue to their provider representative with Amerigroup and was told that since 45 days had elapsed, these claims could not be appealed. Update from Ms. Prevost: Amerigroup has now agreed to reprocess these claims for payment.

Ms. Prevost indicated they are having a problem with Amerigroup's interpretation of the 3-day payment window (72-hour rule). The example she provided is if a patient is seen in the ER for an injury and returns within 72 hours for additional x-rays or surgery, Amerigroup will not pay for both outpatient visits. She indicated the 72-hour rule applies to outpatient services or inpatient services provided within 72 hours of another inpatient visit/admission. Ms. Prevost indicated she has been working with Debra Hand at Amerigroup but feels Debra is not able to resolve the issue. Ms. Davison and Ms. Scott took the claim examples offered by Ms. Prevost and advised they will research the issues.

Amerigroup reported after the meeting that they had reviewed the claim examples provided and responded to Floyd Medical Center on 11/19/07 via e-mail with a copy sent to Myers and Stauffer. Amerigroup noted that Floyd did not provide any claim problem examples related to ER/X-rays as mentioned above. Amerigroup's review documentation indicates that all claims in the example paid or denied appropriately. The provider was invited to call Amerigroup once they had reviewed this information to discuss additional questions.

Ms. Prevost indicated she has several newborn claims that were originally paid by Amerigroup but are now being recouped. Ms. Scott indicated that DCH has identified multiple duplicate eligibility records. In some cases, the member has two records with the CMO but in other cases, the member may have multiple records at multiple CMOs. As the records are merged, payments may be

recouped if the member was not eligible with Amerigroup. However, the claims can be resubmitted under the corrected member ID with the corrected CMO and the time filing limit will be waived. Ms. Scott indicated that Amerigroup has placed all recoupments, related to duplicate member records, on hold until the eligibility records are merged because it was creating too much confusion.

Amerigroup reported that they have been told by DCH that they expect to complete the member duplicate merge cleanup in the first quarter 2008. At that time, Amerigroup will be able to review appropriate overpayments and address specifically with each facility.

Ms. Scott advised Ms. Prevost that Amerigroup has a new hospital provider representative who will work with the hospital to review on-going claim or operational issues as they arise. In addition, Amerigroup offered to set up monthly meetings with Ms. Prevost, similar to the Joint Operating Committee (JOC) meetings currently held with contracted providers to help address any issues she encounters as they occur. Amerigroup also offered to complete a hospital orientation for Floyd Medical Center.

Status: Resolved. A response on the claim examples was provided to Floyd on 11/19/07 (with a copy to Myers & Stauffer). In addition, a meeting has been scheduled for the first JOC meeting on December 21, 2007.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: Peach State
Hospital Provider: John D. Archbold Memorial Hospital

Date: November 8, 2007
Time: 11:00 a.m. to 12:00 p.m.

CMO Participants:
Michael Cadger, President and CEO
Sara Neale, Director Ethics and Compliance

Hospital Participants:
Lynne Fritz, Vice President of Revenue Management

M&S Participants:
Beverly Dilley, Manager
Terri McLean, Sr. Health Policy/Reimbursement Analyst

Description of Issue: Labs are being reimbursed at the wrong percentage of the Medicaid Fee Schedule.

Discussions: Beverly Dilley read the description of the issue and asked Ms. Fritz to explain the issue. Ms. Fritz explained that Archbold has five hospitals. Ms. Fritz explained that Archbold's contracts contain escalators and are very complex. Page 38 of the contract begins the sections that identify the rates by hospital. They performed an audit and found the default OP CCRs were erroneously loaded therefore OP payments were incorrect, inpatient DRG rates were incorrect, and lab payments were paid at the wrong percentage of Medicaid All errors were occurring in all hospitals in the system. Archbold's contract load discrepancies were identified early on (Nov-Dec 2006) but it has taken several months for PSHP to identify the internal problems with the load. Archbold has not yet received verification the issues have been corrected. They are also waiting on news of when the claims will be corrected and payment variances settled. Ms. Neale indicated Peach State has recently implemented a testing system called AmiTest that will produce a report showing the rates loaded for each facility. The reports for Archbold are currently running but are not

complete. Once the report is completed, a copy will be provided to Ms. Fritz so she can verify the rates are loaded correctly before claims are reprocessed.

Ms. Fritz indicated they have encountered problems with providers being added to their hospital TIN who are not associated with the hospital. Archbold is receiving PMPM administrative payments for these providers. Archbold has not cashed the checks and has been returning them to Donna Henley at Peach State. Ms. Fritz has received no follow up from Peach State and the checks have not been reissued. Ms. Neale indicated she would look into the issue.

Ms. Fritz expressed concern about the process for correcting provider records and rate files. She indicated that the corrections are often identified with Ms. Henley but they must be forwarded to another office in another state to be entered. Mr. Cadger advised Ms. Fritz that he is reorganizing the provider relations department and they will have dedicated people who will be able to enter data directly into the system and make corrections on the spot.

Ms. Fritz indicated that she has also had contract loading issues with Cenpatico, the behavioral health vendor. The Archbold contracts were not loaded initially. When the contract was loaded in May of 2007, the claims were denied for non-par physicians and therapist "providers." Claims have still not been corrected. Ms. Neale indicated she would follow up on the issue.

Ms. Fritz indicated that Archbold received a transfer baby from [another hospital provider] and Peach State refuses to authorize care. Mr. Cadger indicated DCH policy states the originating hospital is responsible for the bill.

Ms. Fritz indicated that she is having an issue with electronic billing. When the provider billing number is in field 24J (the designated location), the Peach State mapping logic reads it as a tax identification number and rejects the claim. Ms. Neale advised that she would review the issue.

Status: Unresolved. Peach State will follow up with Archbold and copy Myers and Stauffer.

On December 6, 2007, Ms. Neale indicated the following, "It is the intention of PSHP to meet and discuss all the interview[s] held last month and do a recap of actions taken since these meetings. That meeting is scheduled for Dec 20th and I hope to send our conclusions to you by the end of December. We are continuing to actively work to resolve these issues identified."

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: Peach State
Hospital Provider: Children's Healthcare of Atlanta (CHOA)

Date: November 7, 2007
Time: 10:30 a.m. – 11:30 a.m.

CMO Participants:
Michael Cadger, President and CEO
Sara Neale, Director Ethics and Compliance

Hospital Participants:
Toby Thomas, Vice President Managed Care
Wes Adams, Director Patient Financial Services

M&S Participants:
Beverly Dilley, Manager
Terri McLean, Sr. Health Policy/Reimbursement Analyst

Description of Issue: CMO denied ER claim that occurs within 48 hours of another ER claim, despite contract to the contrary.

Discussions: Beverly Dilley read the description of the issue and asked Ms. Thomas to explain the issue. Ms. Thomas indicated that ER visits within 48 hours of another ER visit were being denied as included in the global period of the first ER visit. Ms. Thomas indicated this issue was also affecting labs and x-rays. Ms. Thomas indicated that the issue had been identified in September 2006 and they had been working with Yolanda Spivey at Peach State. Ms. Thomas indicated Ms. Spivey has advised her that the system edit causing the denials has been corrected and the claims will be reprocessed for payment on November 15, 2007. Ms. Dilley advised Mr. Cadger and Ms. Neale that any issues resolved after the audit commenced might not be identified in the findings if Myers and Stauffer is unaware that the issue has been resolved. However, Peach State would have an opportunity to provide an updated status on any issues noted.

Ms. Thomas indicated they had experienced multiple issues with providers and reimbursement contracts not being loaded accurately and in a timely manner. Mr. Adams indicated that CHOA has $3.2 million in billed charges for professional fees from employed physicians who have not yet been entered in the Peach State system. Mr. Cadger asked Mr. Adams what Peach State's liability was for those claims. Mr. Adams indicated he did not have those numbers. Ms. Neale acknowledged that there had been some delays with the loading of providers and rate schedules. Ms. McLean asked Ms. Neale and Mr. Cadger what Peach State's general timeframe was for adjusting or correcting previously denied or inappropriately paid claims once a provider record was loaded or corrected. Ms. Neale indicated it is the provider's responsibility to identify those claims and resubmit them for reconsideration once the provider record is loaded or corrected.

Mike Cadger indicated that Peach State identifies provider concerns and works to correct them. Peach State is meeting with CHOA weekly to address identify concerns. Peach State is also conducting a provider data clean up project wherein they will review every provider record for accuracy and correct any errors in the provider set up.

Ms. Dilley asked Mr. Cadger and Ms. Neale how system issues were prioritized. Ms. Neale responded that the issues are reviewed daily and re-prioritized each day depending upon the number of claims affected and the financial impact of the issue. Ms. Thomas indicated processing errors cause a significant amount of erroneous denials and the cost of researching the issues is expensive. Ms. Thomas indicated the volume of issues is higher with Peach State than with the other CMOs and the timeline for resolution is longer. Ms. Thomas advised Ms. Neale and Mr. Cadger that it would be helpful if CHOA could receive a copy of the Issue Management (CR) Log with Updates showing the status of the issue. Ms. Neale advised that would not be a problem. Ms. Dilley asked if the timeliness edits are turned off when claims are reprocessed after an issue is resolved and Ms. Neale confirmed they were.

Ms. Thomas indicated there are two issues that have been outstanding for an extended period of time: (1) authorizations not matching to claims resulting in erroneous denials and (2) claims held for children entered as SSI and Peach State. Ms. Thomas asked if the authorization process could be suspended until the system issue was resolved. Ms. Neale advised that there is not a system issue with the authorizations. The claims are denying for no authorization because the authorizations are not matching. Ms. McLean asked Ms. Neale to describe, in general terms, how the authorization matching process works. Ms. Neale indicated the authorization must match the claim on all points including but not limited to the recipient, provider, date of service, location of service, units of service and procedure code. Ms. Neale indicated that the authorizations were not matching because of operator error when entering the authorizations at

Peach State. Ms. Dilley asked Ms. Neale if the authorization must match on procedure code or procedure code family and Ms. Neal indicated procedure code family. Ms. McLean asked Mrs. Neale if the claim suspends if there is a partial match and Ms. Neale indicated that the claim automatically denies if any part of the authorization does not match and the provider is responsible for contacting Peach State and determining what portion of the authorization did not match, have the authorization corrected and re-submit the claim for reconsideration. Ms. McLean asked Ms. Neale what audits were in place at Peach State to address the authorization entry errors. Ms. Neale indicated they have daily reports that are generated to show authorizations that are incomplete or authorizations that are not properly closed. The reports are given back to the person who entered the authorization to complete the authorization and close it. Ms. McLean asked Mrs. Neale if the authorizations are reviewed to compare the authorization information submitted to the authorization information entered to determine accuracy and Ms. Neale indicated no.

Mr. Cadger discussed his career accomplishments and indicated he was hired at Peach State six weeks ago and has several plans for restructuring. Mr. Adams and Ms. Thomas advised Mr. Cadger that they were very pleased with their current provider contact, Ms. Spivey and asked if they would still be working with her. Mr. Cadger advised he would ensure that Ms. Spivey would remain their primary contact. Ms. Thomas requested the ability to escalate issues if they remain unresolved for a specific period of time. Mr. Cadger agreed.

Mr. Cadger asked Mr. Adams what CHOA is doing about credit balances and overpayments they receive. Mr. Adams advised Mr. Cadger that credit balances are reconciled daily and refunded within two weeks. Mr. Cadger advised Ms. Dilley and Ms. McLean that many providers keep money they are overpaid and he believes that part of the audit should focus on providers who do not return money to the CMOs because he feels their activity is fraudulent. Mr. Cadger offered to provide a list of providers who he believes are inappropriately keeping erroneous payments.

Mr. Adams indicated CHOA has several large claims outstanding for members who were enrolled in Peach State and later became eligible for SSI. Mr. Cadger indicated that DCH had issued a retroactive mandate for the CMOs to cover these members but had not funded this mandate. Mr. Adams indicated that CHOA had provided services in good faith and would like these claims resolved. Mr. Cadger indicated that the issue was in the hands of the DCH commissioner because DCH either needs to fund the mandate or reverse it because the CMOs should not be held responsible for paying services related to these members unless they received additional monies from DCH. Mr. Cadger suggested that both parties needed to contact DCH and insist on a resolution.

Ms. Thomas asked Ms. Neale if she could look at the authorization process for rehabilitation. Ms. Thomas indicated that the authorizations are often extended rather than creating a new authorization when services go past the original authorization period. The system is not able to match the authorization when it is extended because the dates do no match exactly. Ms. Neale indicated she was aware that this was an issue and they have instructed their staff to stop extending authorizations and begin entering a new authorization. Ms. Neale indicated she would follow up with the staff to ensure this process was being followed.

Ms. Dilley thanked all parties for their participation and asked that M&S be copied on all resolution correspondence.

Status: Unresolved. Peach State has indicated the original issue is resolved but CHOA is unable to confirm this until after November 15th, 2007.

Per Ms. Thomas via e-mail on 11/16/07,

> "As you may recall, we discussed the fact that Peach State had committed to pay Children's by 11/15/07 for outstanding professional and other claims that had remained unpaid since 6/1/06 due to lags in provider loading at Peach State (which was a key problem reported for Peach State). You will note that we discussed with Mike Cadger our expectation of approximately $XXX in payment for these services. As of 11/16/07, we have not received payments near the magnitude from Peach State to include these payments."
>
> "As you may recall, Mike Cadger of Peach State advised that he had not authorized Peach State staff to pay claims on children who were dually eligible for coverage by a CMO and by the traditional Medicaid program under SSI because he had not received written documentation from DCH to this effect. Further, he advised that the actuarially determined rates payable to the CMOs from DCH had not contemplated coverage of these enrollees. You may also recall that Kathy Driggers provided Children's with a memorandum, dated September 2007, describing when a CMO would be accountable for payment of an inpatient claim. When we left DCH's offices, we were under the impression that only Peach State objected to the expectation of payment of these claims; however, last Thursday, we learned from Susan Kohler of WellCare that Mike Cotton had also directed WellCare staff not pay these claims for reasons similar to those described by Mike Cadger. I sent Kathy Driggers an email message to this effect seeking advice on next steps, but I have not yet received a response. I include this so that you are aware that this problem continues."

On December 6, 2007, Ms. Neale indicated the following, “It is the intention of PSHP to meet and discuss all the interview[s] held last month and do a recap of actions taken since these meetings. That meeting is scheduled for Dec 20th and I hope to send our conclusions to you by the end of December. We are continuing to actively work to resolve these issues identified.”

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: WellCare
Hospital Provider: Children's Healthcare of Atlanta (CHOA)

Date: November 7, 2007
Time: 2:00 p.m. to 4:00 p.m.

CMO Participants:

Mike Cotton, Chief Operating Officer (via conference call)

Hospital Participants:

Toby Thomas, Vice President Managed Care
Wes Adams, Director, Patient Financial Services
George Dilworth, Director, Finance Managed Care

M&S Participants:

Beverly Dilley, Manager
Holly Ross, Sr. Health Policy/Reimbursement Analyst
Terri McLean, Sr. Health Policy/Reimbursement Analyst

Issue #1: CMO does not provide information regarding changes it makes to inpatient ICD diagnosis and procedure codes which result in a grouping to a different DRG

Discussions: Beverly Dilley read the description of the issue and asked Ms. Thomas to explain the issue. Ms. Thomas indicated that CHOA is submitting inpatient bills. WellCare is reviewing the medical records and changing the ICD diagnosis and procedure codes causing the claim to group to a different DRG. Ms. Thomas indicated that WellCare does not notify CHOA that the claim has been regrouped to a different DRG or on what basis the decision was made to regroup the claim. Mr. Cotton indicated that WellCare does perform retrospective reviews of inpatient claims and it is WellCare's procedure to notify the provider when the DRG is changed. Mr. Cotton agreed that the provider should be notified and will look into the process to confirm that letters are being sent to CHOA.

Ms. Thomas indicated that Carmen Boget at CHOA has been working with Janae at WellCare to review the claims data and attempt to identify why the claim paid differently. Ms. Thomas asked Mr. Cotton how the claims are selected. Mr. Cotton indicated the selection is random. Ms. Thomas and Mr. Adams indicated the selection focused mostly on specific NICU DRGs. Mr. Cotton indicated that the NICU DRGs are high volume DRGs at CHOA so those claims are more likely to be selected.

Status: Resolved. WellCare will research provider notification issue and respond to CHOA and copy Myers and Stauffer.

In an e-mail dated November 16, 2007, Ms. Thomas provided this update:

"As you may recall, Mike Cotton advised that:

- He would contact me by the following Tuesday to respond to our request for detail when WellCare changes a DRG assignment on one of our IP claims (because their medical reviewers advise that they cannot identify in the medical record the same ICD 9 diagnosis and procedure codes as those we submitted on our bill). While I did not receive any response from Mike, we have begun to receive detail on our electronic remittance statement such that we can identify that the reason for a variance from our expected payment rate is the result of a different DRG assignment by WellCare.
- Our weekly claims follow-up sessions, that include WellCare's claims manager in Tampa, could be expanded from one to two hours each week to accommodate the high volume of claim variances we must review to be paid. Susan Kohler, one of the participants in our weekly calls, reports that she has not been advised of this commitment, and Ashley Craigin of WellCare reports that the claims manager (Brian Pogue) is a corporate (Tampa) resource, not a Georgia resource. As a result, it appears that it is unclear whether Mike is able to commit a Tampa resource to an expanded weekly meeting commitment. In any event, our claim meeting timeframe has not been expanded.

As you may recall, Mike Cadger of Peach State advised that he had not authorized Peach State staff to pay claims on children who were dually eligible for coverage by a CMO and by the traditional Medicaid program under SSI because he had not received written documentation from DCH to this effect. Further, he advised that the actuarially determined rates payable to the CMOs from DCH had not contemplated coverage of these enrollees. You may also recall that Kathy Driggers provided Children's with a memorandum,

dated September 2007, describing when a CMO would be accountable for payment of an inpatient claim. When we left DCH's offices, we were under the impression that only Peach State objected to the expectation of payment of these claims; however, last Thursday, we learned from Susan Kohler of WellCare that Mike Cotton had also directed WellCare staff not pay these claims for reasons similar to those described by Mike Cadger. I sent Kathy Driggers an email message to this effect seeking advice on next steps, but I have not yet received a response. I include this so that you are aware that this problem continues."

In an e-mail dated December 6, 2007, Ms. Toby Thomas stated,

"We agree that WellCare has addressed the #1 DRG notification issue and we consider it resolved.

Please note, however, that we were never concerned about WellCare's documentation associated with its requests for refunds when it determines that the DRG initially paid was different from the one that should have paid (after reviewing our medical record) [via retrospective review] - i.e., the examples attached to this email.

Instead, we were concerned about instances when WellCare's initial DRG payment to Children's differed from the expected DRG payment. In these instances, we assumed WellCare was routinely conducting medical record reviews and assigning a different DRG before the initial claim payment to Children's. We assumed this because i) WellCare requests hundreds of Children's IP records for review; ii) we could not tell from the info received with the payment that the variance was on account of a different DRG assignment by WellCare or if WellCare had calculated a different payment rate for the DRG we expected to be paid.

WellCare is now sending the DRG they assigned on the electronic remittance statement. Using this, we can now determine whether the WellCare payment variance is on account of a different DRG assignment or whether the difference is due to a miscalculated DRG rate. If the variance is due to a different DRG assignment, we still have to follow-up with WellCare to understand how they resequenced the diagnoses and procedures billed and then ask our coding staff to review for concurrence, but at least we can narrow down the reason for the variance."

Issue #2: WellCare pays 75% of ER claims at triage rate then overturns 40% upon appeal (provider appeals 100% of triage payments). WellCare does not use prudent layperson standard in that consideration is not given to the age of the patient, time of visit or combinations of diagnoses billed, including the

admitting diagnosis. CMO will not incorporate findings from appeals process in updating process for paying ER claims.

Discussions: Ms. Thomas indicated that WellCare pays 77% of ER visits at triage rate as compared to 19% by other CMOs and 10% for commercial payors. CHOA appeals all claims paid by WellCare at triage rate and 40% are overturned. CHOA performed an analysis of ER appeals overturned and provided WellCare with a list of situations when the claim is almost always overturned and asked WellCare to consider revising ER criteria based on appeal results. Mr. Cotton indicated ER claims are "reconsiderations" rather than appeals and referenced a message on their web portal regarding ER reconsiderations. Ms. Tomas indicated WellCare offers no feedback on the reconsiderations to explain why the decision was made so CHOA is unable to appeal the decision.

Mr. Adams indicated that WellCare's policy states that the ER visit is approved if the primary care physician refers the patient to the ER or if WellCare's Nurse Advice line refers the patient to the ER. Mr. Adams asked Mr. Cotton if there is any communication to the claim system to indicate the referral has been made. Mr. Cotton indicated that there is no communication between the systems. Ms. Thomas complimented WellCare on their initiative in contacting the patients who have been to the ER and attempting to educate them on proper use of ER services. Ms. Thomas asked Mr. Cotton if the information gathered from those calls is integrated with the claim payment system to indicate the claim should be paid at the emergency rate rather than the triage rate. Mr. Cotton indicated there is no integration.

Mr. Cotton indicated he would be open to negotiating [an alternative reimbursement methodology] with CHOA.

Status: Unresolved. CHOA suggested that the solution might be to allow an Administrative Law Judge review the issue.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: WellCare
Hospital Provider: HCA - Georgia

Date: November 8, 2007
Time: 10:00 PM – 11:30 PM

CMO Participants:
Michael Cotton, Chief Operating Officer

Hospital Participants:
Vi Crain, Interim Director of Payment Resolutions

M&S Participants:
Jared Duzan, Principal
Holly Ross, Sr. Health Care Policy/Reimbursement Analyst

Description of Issue:

- CMO paying utilizing short stay/transfer provisions instead of DRG rate even though this is not specified in the contract.
- CMO applying traditional outpatient (OP) caps even though there is no provision in the contract.
- CMO not paying for all non-listed labs and ambulatory charges at contract percentage rate.

Discussions:

Mr. Duzan and Ms. Ross greeted the participants. Mr. Duzan explained the purpose of the meeting was to discuss only the issue presented to the participants. Mr. Duzan then turned it over to the provider to present their supporting documentation for the issue.

Ms. Crain, HCA-Georgia, explained that WellCare's contract with Georgia's HCA facilities does not have a short stay/transfer provision. HCA is unable to reconcile to what they are being paid, however, they have been told they are being paid at the Georgia Medicaid CCR

reimbursement (short stay) rate. HCA was not expecting any reduction in payment for inpatient claims where the patient's length of stay did not exceed 1 day since there is no short stay provision included in their contract. HCA believes that since the contract with WellCare states under Article IV (Compensation) that WellCare will pay the facility based on payment terms outlined in Attachment A of the contract payment should be made for these services at the contracted DRG reimbursement case rate (XXX% of Facility Operating Rate x DRG Relative Weight + XXX% of Facility Add-On Rate).

Mr. Cotton, WellCare, responded by stating WellCare pays based on Medicaid guidelines, which includes a short stay calculation on page 54 under section F.

Ms. Crain explained that a similar circumstance exists for outpatient services. WellCare's contract with Georgia's HCA facilities does not have an outpatient maximum case rate provision, however, WellCare is applying the traditional Georgia Medicaid outpatient maximum allowable payment rate. There is no language in the HCA and WellCare rate agreement (Attachment A of the contract) regarding an outpatient maximum. As a result, HCA expects to be reimbursed the contracted percentage on all billed charges (XXX% of Facility's Billed Charges x CCR) for anything not on the fee schedule or not listed under a different reimbursement rate in the contract.

Mr. Cotton responded that perhaps it is not explicit in the contract, however, WellCare follows the Outpatient Manual and references page 54, section F of the manual. He reiterated that Medicaid guidelines are followed. Mr. Cotton stated Art Weinblatt and Pamella Tucker of HCA have also spoken with him on this topic and they may have a resolution as they are working on an amendment and new contract in January.

Ms. Crain asked if this was only a prospective resolution or a retrospective resolve as well which will address the claims she is referring. Mr. Cotton responded indicating the amendment is prospective, but she may want to discuss this further with Art and Pam to see what they had in mind.

Ms. Crain responded that she understood the current contract to read that the WellCare manual supercedes all other manuals. Mr. Cotton responded that is incorrect but rather the contract states payment is made in accordance with Georgia Department of Community Health (DCH) guidelines.

Ms. Crain presented that WellCare is not paying non-listed laboratory and ambulatory charges at the contract percentage rate. HCA expectations are to be reimbursed for all non-listed laboratory and ambulatory charges at the contract percentage rate. It is HCA's understanding that reimbursement for outpatient services not listed under the Outpatient Clinical Diagnostic Laboratory fee schedule rates or under the Free Standing Ambulatory Surgery Center fee schedule rates are defaulted to be reimbursed at a percentage of the facilities billed charges multiplied by the facility specific cost to charge ratio (CCR).

Mr. Cotton responded by asking if the services to which HCA is referring are state lab services. There is no fee schedule for state lab expenses. If a procedure is not listed on the DCH fee schedule because it is sent to state labs, WellCare would not list the procedure or pay for the procedure.

Ms. Crain stated that she would send Mr. Cotton a sample of these claims for review since she is uncertain if these are state lab service claims.

Documentation is to be sent to Mr. Cotton's attention.

Mr. Duzan requested that Myers and Stauffer be copied on all correspondence.

Issue Status: Unresolved. WellCare will review sample documentation to be provided by HCA. Following some additional research on the issues presented, WellCare will respond to HCA – Georgia and copy Myers and Stauffer.

In an e-mail dated December 14, 2007, from Mike Cotton, Mr. Cotton states,

> "We continue to work on renegotiating our agreement, to include moving to DRG Grouper 24, consistent with DCH's change effective January 1, 2008, increasing their ER Triage Fee and amending language to remove the "lesser of" payment provisions currently consistent with our payment policy. We believe we our payment policy of adhering to DCH guidelines are clear in our provider manual and contract language and will continue to include these provisions in our contract going forward. We believe our decision to remove the "lesser of language" and increasing the triage fee will be accepted to move forward with the amendment. "

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
Care Management Organization (CMO)/Hospital Provider Meetings
November 7 and November 8, 2007 at DCH – 36th Floor
Notes prepared by Myers and Stauffer LC (M&S)
The Hospital and CMO have reviewed and commented on these notes.

CMO: WellCare
Hospital Provider: Bacon County Hospital

Date: November 7, 2007
Time: 12:00 PM – 2:00 PM

CMO Participants:

Michael Cotton, Chief Operating Officer, via conference call

Hospital Participants:

Janet Johnson, Financial Services Manager
Marie Barefoot, Medicaid Reimbursement Specialist

M&S Participants:

Jared Duzan, Principal
Holly Ross, Sr. Health Care Policy/Reimbursement Analyst

Description of Issues:

Issue #1: CMO is not paying for anesthesia professional fees billed for Certified Registered Nurse Anesthetists (CRNAs). These claims are being denied with an explanation code of NOFEE (procedure code not on fee schedule) and DN025 (no contractual fee allowance).

Issue #2: Not all claims for emergency room (ER) professional fees are being paid. Claims were initially denied because provider was told physicians did not need a WellCare ID but they did. Then claims denied because WellCare stated the address in box 32 was wrong, as well as the wrong tax ID. There appears to be an issue with set up/contract loading since ER professional claims that say “Bacon County Community Care” (incorrect name) are paid and claims that say “Bacon County Hospital” (correct name) are denied.

Discussions:

Mr. Duzan and Ms. Ross greeted the participants. Mr. Duzan explained the purpose of the meeting was to discuss only the issue presented to the participants. Mr. Duzan then turned it over to the provider to present their supporting documentation for the issue.

Issue #1:

Ms. Johnson explained that Bacon County Hospital recently received their first payment on an anesthesia professional fee claim billed for a CRNA. Payment was made via check number 1000367148 dated October 9, 2007 and covered services provided the end of September. From Bacon County Hospital's perspective, they are pleased to have received this recent payment but are uncertain as to why this claim paid given it is similar to the previously denied claims for which they believe they are entitled to payment. As of September 24, 2007, Bacon County Hospital has anesthesia professional charges exceeding 120 days totaling just over $XXX. Bacon County Hospital personnel have discussed the outstanding receivables with their WellCare provider representative, Jackie Rentz. Anesthesia claims prior to the recent payment were denied with an explanation code of NOFEE (procedure code not on fee schedule) and DN025 (no contractual fee allowance). Clarification was requested from the WellCare provider representative regarding the meaning of these denial codes. Sample claims illustrating this issue were provided to their representative on multiple occasions, but no resolution has been reached as of this meeting.

Mr. Cotton responded by asking if the CRNAs are under contract with the hospital. Ms. Johnson indicated that the CRNAs are employees of the hospital, therefore, the hospital tax ID number is used but the CRNAs have their own Medicaid number and NPI number.

Mr. Cotton stated that each provider needs their own professional ID. He then concluded that WellCare's system may not be setup for Bacon County Hospital to bill anesthesia services and the providers may need to be setup as "Non PAR". Mr. Cotton requested documentation that illustrates the issue. Ms. Ross, Myers and Stauffer, asked if they could provide Mr. Cotton with claim reference or remittance number during the meeting so he will have a few sample cases to look at right away. Mr. Cotton agreed that would be helpful and the following information was provided: a.) Recently paid remittance advice check number ##### and claim number ######. b.) Outstanding account receivable remittance advice check number ###### and claim numbers ####### (NOFEE denial code) and ###### (DN025 denial code). Mr. Cotton also requested copies of documentation for additional research. Ms. Barefoot indicated that they could provide that information. Mr. Duzan asked when the

information would be available to Mr. Cotton. Ms. Johnson responded that the information could be sent Monday, November 12, 2007. Mr. Duzan then asked Mr. Cotton how much time was necessary to research the issue and provide a response to Bacon County Hospital and Myers and Stauffer. Mr. Cotton stated he would need to get back with Mr. Duzan on that question since he would like to review the documentation before committing to a response timeframe.

Documentation is to be sent to Mr. Cotton's attention.

Mr. Duzan requested that Myers and Stauffer be copied on all correspondence.

Issue Status: Resolved. WellCare will research the anesthesia (CRNA) professional fee billing issue and respond to Bacon County Hospital and copy Myers and Stauffer. See Mike Cotton e-mail below regarding resolution.

Issue #2:

Ms. Johnson explained that not all claims for emergency room (ER) professional fees are being paid. Initially, claims denied because Bacon County Hospital was told physicians did not need a WellCare ID but they did. As a result, the hospital applied for and obtained separate WellCare numbers for their ER physicians. Ms. Barefoot explained that they thought this would resolve the issue but then claims denied because WellCare stated the address in box 32 was wrong, as well as the wrong tax ID. After speaking with a WellCare representative in Tampa Florida, who indicated that the box 32 issue had to do with the way the hospital's software was set up, the hospital contacted their software people at Health Systems Resources. A programmer at Health Systems Resources assisted the hospital in making the software changes recommended by WellCare. After these changes, Bacon County Hospital has received payment for some but not all of its outstanding ER professional fee charges. Bacon County Hospital still has ER professional fees that are over 120 days old.

Mr. Cotton confirmed that the address field must be an exact on match. He agreed to double-check what the field needs to look like.

Ms. Barefoot commented that Bacon County Hospital is still getting letters of denial concerning the tax ID number being incorrect. Ms. Johnson and Ms. Barefoot stated that claims with the same tax ID are appearing under two different names on the WellCare remittance advices. Remittance advices are showing Bacon County Hospital sometimes and Bacon

County Community Care Center other times despite the claim indicating Bacon County Hospital. This has been brought to WellCare's attention by contacting the Bacon County Hospital provider representative, however, no resolution has been reached as of this meeting.

Mr. Cotton responded by stating he will validate provider and tax ID numbers with the Bacon County representatives to work with them on resolving this issue. Mr. Cotton stated he would be happy to arrange an on-site visit with Bacon County Hospital so they can work through these issues in person, if necessary.

Ms. Johnson and Ms. Barefoot stated they were open to a possible on-site visit with Mr. Cotton. They will provide Mr. Cotton with the documentation pertaining to this issue for his review.

Mr. Duzan requested that Myers and Stauffer be copied on all correspondence.

Issue Status: Resolved. WellCare will research ER professional fee billing issue and respond to Bacon County Hospital and copy Myers and Stauffer. See Mike Cotton e-mail below regarding resolution.

In an e-mail dated December 14, 2007, Mr. Cotton states,

> "We have provided instructions to Marie Barefoot and Bacon regarding appropriate billing for their affiliated hospital-based providers and for anesthesia services (Bacon excluded time units on their anesthesia bills - this apparently was never limited by ACS for payment but is a CMS - Medicare requirement). They will also place the correct information on the 1500 form in boxes 31, 32, and 33 (must reflect location of service; not a P.O. Box). These changes will eliminate their front-end rejections and result in automatic payment. We are also over-riding our system to pay all current claims and have advised them in writing (copy attached) that all future claims must be billed correctly."

Attachment D

Initial Meeting Attendees List

CMO Meetings

For each of the 3 meetings listed below, the following representatives from DCH and Myers and Stauffer were in attendance:

- John Upchurch, DCH
- Jared Duzan, Myers and Stauffer
- Ryan Farrell, Myers and Stauffer
- Beverly Dilley, Myers and Stauffer

Tuesday, September 18, 2007

10:00 AM, Peach State Health Plan

- Jonna Kirkwood, Vice President, Operations
- Debra Peterson-Smith, Vice President, Member & Provider Services
- Matthew Richardson, Director, Process Improvement
- Kristy Whitmore (via conference call)
- Nick Hockenhull (via conference call)
- Herbert Spencer (via conference call)
- Steve Pace (via conference call)

11:00 AM, Amerigroup

- Craig Bass, President, CEO
- A number of participants from the Virginia Beach office (via conference call)

1:00 PM, WellCare

- Phil Wasden, Regional Vice President, Operations
- Susan Kohler, Director, Health Services Operations
- Christopher Bethel, Directory, Regulatory Affairs, Georgia
- Brian Pogue, Regional Manager, Georgia

Hospital Provider Meetings

For each of the 4 meetings listed below, the following representatives from Myers and Stauffer were in attendance:

- Jared Duzan
- Beverly Dilley
- Ryan Farrell

Tuesday, September 25, 2007

10:00 AM, Home Town Health, LLC

- Kathy Whitmire, Managing Director, Home Town Health
- Patty Whitmarsh, COO, Health Resources Group
- Lynn Fritz, VP Revenue Mgmt, John D. Archbold Memorial Hospital
- Elizabeth Spoto, Spoto & Associates
- Sandy Sage, RN, Fairview Park Hospital
- John Williamson, CFO, Upson Regional Medical Center
- Hari Best, Business Office Mgr, Flint River Community Hospital

11:00 AM, Children's Healthcare of Atlanta (CHOA)

- Ruth Fowler, Sr. VP of Finance
- Toby Thomas, VP of Managed Care
- George Dilworth, Director of Managed Care Finance
- Wes Adams, Director of Patient Financial Services
- Marti Zeigler, VP of Revenue Cycle

12:00 PM, VHA

- Michael S. White, VP Business Development and Operations, VHA
- Teresa Prevost, Director Revenue Management, Floyd Medical Center
- Tom Lynch, VP Managed Care, ED, Gwinnett Health Systems

1:30 PM, GHA

- Janet Johnson, Bacon County Hospital
- Marie Barefoot, Bacon County Hospital

- Cindy Turner, Bacon County Hospital
- Cathy Patterson, Medical Center of Central Georgia
- Lisa Watson, Memorial Health
- Wayne Senfeld, Tanner Behavioral Health
- Althoria Warren, Blankenship & Associates (Henry Medical Center)
- David Blankenship, Blankenship & Associates (Henry Medical Center)
- Maura Williamson, University Hospital, Augusta
- Charlotte Vistal, Crisp Regional
- Robert E Bolden, GHA
- Rhett Partin, Center for Rural Health, GHA
- Margie Coggins, Chmn Mickey Channell, House Budget Office
- Temple Sellers, GHA
- Sabrina Sims, Dekalb Medical Center

Wednesday, September 26, 2007

9:00 AM, Flint River

- Hari Best, Flint River
- Beverly Dilley, Myers and Stauffer
- Ryan Farrell, Myers and Stauffer

10:00 AM, CHOA

- Wes Adams, CHOA
- Toby Thomas, CHOA
- George Dilworth, CHOA
- Beverly Dilley, Myers and Stauffer
- Ryan Farrell, Myers and Stauffer

11:00 AM, Tanner Health System

- Wayne Senfeld, Tanner Health System
- Amy Waddell, Asst Dir., Behavioral Health, Tanner Health System
- Paula Gresham, Sr. Mgr., Behavioral Health, Tanner Health System
- Jared Duzan, Myers and Stauffer